THE CHILDREN'S TREATMENT UNIT

SERVICE AREA PROFILE

THE CHILDREN'S TREATMENT UNIT

MISSION:
TOGETHER WE PROVIDE AN ENVIRONMENT WHERE CHILDREN CAN ACHIEVE "WHOLENESS"
SUPPORTING VALUES:

1. Teamwork.
2. Consistency.
3. Staff being positive "Role Models".
4. Each child needs to feel important.
5. Each child needs to feel "Safe".
6. Build on "Patient Strengths".
7. Staff must see events through the eyes of the patients.
8. "Empower" patients.
9. Reunite families.

CHILDREN'S TREATMENT UNIT PHILOSOPHY

In order for a patient to be referred to the Children's Treatment Unit, various community alternatives should have been explored and either exhausted or judged to be inappropriate for the patient. For many interlocking reasons the natural home, foster home, or to her community living arrangement have been unable to contain the child's behavior which then brings him to the attention of various community agencies.

The children who are referred for residential treatment represent a broad range of diagnostic categories (see unit profile). Because of this variety, our approach to treatment must encompass many therapeutic modalities. The treatment program draws upon principles of learning theory, play therapy, and psychodynamic theories along with various psychotropic medications where appropriate.

Many of our patients present themselves as security problems to the public and thus require an extremely tight structure and a great deal of limits while on the other hand, others are very inadequate and withdrawn and require us to provide softness, support and freedoms. Our challenge is to build into our program processes which can provide the tightness of structure for some while encouraging the openness and flexibility for others.

Our philosophy therefore places first the needs for the child to be understood, to feel wanted, to be respected as a person, to be able to trust and go to someone. We are concerned to increase the sense of his own worth and to encourage his known abilities and to find new ones. We aim to overcome emotional deficits by new experiences and by providing enrichment opportunities in recreation and educational settings. This requires a great amount of insight and patience from the staff, because the children so easily alienate sympathy by aggressive and oppositional behavior.

Inevitably the behavior of the children toward each other, toward unit staff and teachers, is a subject for much problem solving. Our treatment goals therefore center around attempts to reduce the negative traits such as aggressiveness, teasing, bulling, tantrums, irresponsibility, etc. with peers, and disobedience, defiance, lying, etc. with staff, to acceptable levels. It is therefore essential that we provide an arena of interaction wherein positive social learning can take place. Our children, besides often expressing their loneliness and emotional stress through aggressive and oppositional acts, are sadly lacking in the skills and attitudes they need to have to get along with each other, We want them to understand how to behave and how to relate to each other in order to get the satisfaction of friendships, of playing and working together. We insist upon standards of behaving and help the children reach these standards. We find that these new behavioral standards are often not easily accepted. Confrontation, consequences, rewards and penalties are aspects of our determination to help these children acquire the necessary social skills.

The fabric which ties the many aspects of treatment approaches together is a "Performance Level" system which takes into account each child's performance across various areas of programming. Level scores are adjusted twice daily in

order to help determine the level of performance and progress of each child. Philosophically the program relies upon a therapeutic milieu. Each child has a special adult called his "One to One", he may also belong to small group that meets regularly with a focus and methods designed to meet the needs of the members of the group. Each of the children are also seen as members of the unit community wherein they have a role and a voice in making some determination as to what types of things happen in the program. Concern for others and responsibility for one's own actions are taught and expected.

The therapeutic milieu offers the child care, concern, love and understanding; it contains his behavior, and it creates an experimental situation for the working out problems with others. The milieu likewise helps to overcome developmental deficits by enriching the child's experience of and expectations of life. We fail if he does not gain in confidence, self-esteem and personal responsibility.

We feel that the child's work is his play and thus see the children as relating best to each other and to the staff during purposeful recreational activities. Great value is placed upon having the children participate in hiking, camping, river running, rapelling, skiing, and simulation games etc. We plan activities which challenge, build skill, give courage and increase self-esteem.

Because many of the children come to us from a distressed family we place a strong emphasis on involving the active parent or parents in a counseling or therapy process. Some of our children have attachment problems, have been abandoned or for some other reason do not have biological parents. In these instances we endeavor to involve both foster and volunteer families with the child and in a counseling process to understand the child's needs and appropriate reactions to those needs.

Another essential area of our treatment philosophy is that each child needs to have a successful educational experience. The vast majority of the children referred have experienced extremely poor school performance and little success in the academic world. Our focus is on providing a warm, positive, inviting environment in a school setting, one which works with each child at his current performance levels, delimits competition with others and encourages self-growth.

The focus of the Children's Unit at the Utah State Hospital is to provide residential care and treatment for youngsters who are seriously disturbed, where the community-based treatment resources have been exhausted and where the child cannot be contained in the community. Because of the limited population in Utah, it is currently not financially feasible to establish a Children's inpatient facility in many communities throughout the State. Therefore, the Children's Treatment Unit here at the State Hospital must serve the entire State as a specialty and backup program for latency and early adolescent age children. Another service performed by the Unit is that of evaluation and treatment recommendations for the juvenile courts throughout the State. Occasionally, we are also asked to evaluate children who appear to be mentally retarded but might be functioning at that level because of serious emotional disturbances.

POPULATIONS SERVED (PATIENT PROFILE)

Criteria for Admission

In order for a patient to be referred to the Children's Treatment Unit, various community treatment alternatives should have been explored and either exhausted or judged to be inappropriate for the patient. The patients who are accepted for treatment in the Unit represent a broad range of diagnostic categories. Most of the children have been previously treated in many agencies, have had specialized school programs, and were tried in alternative living situations (Boys Ranch, Foster Home, etc.) prior to being admitted to this unit. At least 95% of the children present serious behavioral problems which pose a physical threat to either themselves or others, i.e. running away, violence or threats of violence to persons, fire setting and suicidal threats or attempts.
The current program capacity is 22 children. The age limits are 6 through 13. The lower age is set because of our linkage with the school system. Accepting patients in the 13 year old range depends entirely upon their functional abilities. Those who are immature both physically and emotionally and who require a more nurturing atmosphere, are appropriate for this unit.

Diagnostic Categories

The children in the program have one of the following diagnoses:
Post Traumatic Stress Disorder
Pervasive Developmental Disorder
Major Depression
Oppositional- Defiant Disorder
Attention Deficit Disorder
Psychotic Disorder
Dysthymic Disorder
Bipolar
Schizo affective
Tourettes

Patient Problems

1.	Dangerous to self or others	100%
	A. Suicide ideation	60%
	B. Physical Violence	100%
	C. Run-away	50%
	D. Fire-setting	40%
	E. Threats of Violence	100%
2.	Destruction of Property	100%
3.	Hyperactivity	75%
4.	Impulse Control	100%
5.	Limited Frustration Tolerance	100%
6.	Learning Disabilities	80%
7.	Learning Problems-Emotional Caused	90%
8.	Depression	80%
9.	Sexual Reactive	70%
10.	History of Sexual Abuse	85%
11.	Antisocial Behaviors	75%
12.	Excessive Oppositional and Out-of-Control Behavior	100%

TREATMENT REQUIREMENTS

In order to treat the patient problems outlined above, the following treatment modalities are employed by the Children's Treatment Unit staff:

1.	Complete physical, social, nursing, recreational, psychiatric, psychological and educational assessments	100%
2.	Structured, secure, home-like environment	100%
3.	Psychotropic Medication	90%
4.	Specialized Diet	10%
5.	Prescribed Recreation	100%
6.	Diversional Recreation	100%
7.	Family Therapy	90%
8.	Individual Psychotherapy	100%
9.	Play Therapy	95%
10.	Group Psychotherapy	85%
11.	Individualized Behavior Programs	30%
12.	Performance Level System (behavioral evaluation)	100%
13.	Redirection Program	100%
14.	Specialized Educational Programming	95%
15.	Specialized nursing care	5%

PROGRAMMING HIGHLIGHTS

The treatment program of the Children's Treatment Unit has been, and will continue to be, dynamic in that it changes to best maximize the skills and personality of the staff when applied to the individual and varied needs of the children. As the population changes, different aspects of the program become more pronounced.

Level System

The "Level" system is a behavioral program which provides coherence and consistency for the children. This system provides a concrete, observable

means for the individual child to measure his/her behavior.
By this regular evaluation and charting of levels, trends in behavior can be observed. This process also helps focus the attention to the primary therapist on what is happening in the life of each child.

Redirection Program

"Redirection" is a behavior modification technique used on the Children's Unit. The rationale behind it is to momentarily remove the child from the therapeutic community where he receives interaction and positive reinforcement from others, to an unfurnished room where he is treated neutrally. The child is removed from the community interaction when he is exhibiting one or more of the target behaviors, which include: fighting, oppositionalism and provoking.
Incidences of "Redirection" are monitored and charted so they can be used as measures of specific goal achievement.

Play Therapy

Play therapy is a dynamic interpersonal relationship between a child and therapist trained in play therapy procedures. Children's natural language is play; a symbolic language of self expression children use to give expression to their experiences and emotions. The therapist provides selected materials, toys, and activities giving children opportunities to express themselves through a variety of mediums (art, sand tray, water play, dramatic play, fantasy play, experiential play, skill building activities, etc.). Play is a rehearsal for life. Through play therapy, children can recreate at their developmental level, issues representing emotional conflicts influencing their present behavior. Through facilitative skills such as therapeutic limit setting, tracking, empowerment recognition, context restating, reflecting feelings, etc., the therapist helps develop a safe relationship with children allowing them a sense of security when working through their issues.
The objectives of the play therapy process are that children can change their personal view of events in the world and begin to better enjoy their interactions with others. Through play, children are able to communicate what they cannot say, do things they would feel uncomfortable doing, and express feelings they may be keeping inside. They learn self-control, self-direction, and responsible freedom of expression. Children also learn through the play process and relationship to respect themselves, accept themselves, to be creative and resourceful in confronting problems, to make choices and assume responsibility for their choices.
Currently, play therapy is utilized with all of the patients primarily on an individual basis but often in conjoint sessions with other patients and even siblings. In addition, filial play therapy can extend and reinforce the child's therapeutic play experiences from the hospital unit to home by training family members in therapeutic play therapy skills.

Group Therapy

Currently many (some patients are not able to handle group interactions and thus are not placed in groups until the treatment team feels that it would be beneficial to the patient.) patients are assigned to meet in group therapy at least one time per week. The different groups are tailored for the specific populations. The

model of each group is developed by the primary therapist for the specific needs of the patients in the group. Some groups may be activity oriented, while other groups are more traditional. As group members change, so does the focus of the group to more readily meet the needs of the group members.

Victims Group

With the majority of the children at this facility experiencing some form of sexual victimization, a group format has been developed to address the psycho educational aspects of victimization. While some issues of victimization are addressed on an individual basis, the goal of this group for the Unit is to provide consistency in presentation of information among therapists. The clinical team makes recommendations as to which children ought to attend at particular time. The group format consists a psycho-educational orientation emphasizing the following:

1. "I'm in charge of me."
2. "All you gotta say is no."
3. "Feelings"
4. "I'm in charge of my body."
5. "Secret touching."
6. "Perpetrator influences."
7. "Resolution strategies."
8. "Who can I tell?"
9. "Fault and responsibility"
10. "Self esteem building."

Additional group activities are drawn from "Superkids: a boys group about abuse" (Joanne McCharty), to facilitate group objectives. The group is maintained on an open ended format.

Sexually Reactive Group And Individual Therapy:

The Children who have a history of being sexually reactive are considered for placement in the "Sexually Reactive" therapy. It is an open ended therapeutic process that is not time limited. The goal of this therapy is to help the child be able to learn skills and develop abilities to understand and control their sexual thoughts, feelings and behaviors in socially acceptable ways. Treatment issues are addressed which include the following:

1. Ability to Identify Feelings.
2. Anger Management.
3. Relaxation Skills.
4. Empathy Skills.
5. Issues of Accountability.
6. Social Skills.
7. Forming Appropriate Boundaries.
8. Human Sexuality/Maturation.
9. Developing a Healthy Sense of Self.
10. Communication Skills.
11. Cycles.
12. Cognitive Skills.

Several sessions are utilized to address each area and repetition of concepts

takes place according to the needs of each patient or the group.

Individual Psychotherapy

Each child has a primary therapist who meets with him regularly. Individual therapy has many focuses and is tailored specifically to the needs of the child. One basic goal of all individual therapy is to help the child develop trusting relationships with adult figures.

Family Therapy / Community Outreach

Our staff make weekly contact with families and have formalized family therapy sessions as often as possible. Various approaches are used depending on the needs of a particular family. One area which has proven to be very effective is to involve the family in "interactional activities" under the direction of the Recreation Therapist. Family members have also been involved in some of our "off grounds" activities such as skiing. Another area is to use Filial therapy where the therapist works with the parents in the play therapy setting to help the parent gain skills that make a positive impact in the relationship with their child.

When a family is unable to come to the hospital our staff will make efforts to have a session in their home or local mental health center when possible. This effort has been well received, as parents view it as our attempt to meet them more than half way.

Sexual Abuse Treatment

Since many of the children we work with have been sexually abused, we try very hard to work on the treatment issues which have been caused by the abuse. The damage from the abuse is deep seated and takes a great deal of time to help the child cope.

At times, we have special groups focusing on the abuse; but most often, the treatment issues of the abuse are worked on in individual, group, and recreational therapy.

Recreation Therapy

The role of play in the growth and development of children is of utmost importance. Through the play experiences, children are able to explore, experiment, observe and gain experiences that help them to learn about themselves, their families and peers. The play experience also provides the child with valuable opportunities for constructive skill learning.

We are firmly committed to the notion that most of the objectives we are striving for with each child can be accomplished within an activity setting. When a child is involved in an activity, it is for a specific goal attainment.

EXPECTED OUTCOMES

As a result of the programs mentioned above and the rest of our programming, we expect the following:

1. A level of participation on the part of all unit personnel which will help each one feel that he/she are a meaningful factor in the lives of the children.
2. Each child will increase his ability to function in a socially acceptable manner because he has increased in ability to trust, enhanced his feelings of self worth, increased his sense of control over his life and expanded his understanding of his potentials.

3. When a child leaves our facility with an approved discharge, he can be expected to be able to function in a less restrictive treatment
4. Each child's parent figures will have an improved ability to work with the child and understand the effects of the family dynamics on the functioning of their child.

STAFFING PATTERN

In order to meet the unit requirements listed above the following staff are required by the Children's Unit.

1. A child psychiatrist (Unit Clinical Director) to oversee the delivery of clinical services on the unit, perform psychiatric evaluations, provide medical services (including medication) and participate in clinical staffing for each patient.
2. A part time Pediatrician to evaluate physical needs of the patients and provide specialized care and directions where required.
3. An Administrative Director who is responsible for the administrative and supervisory needs of the unit and works closely with the Clinical Director to bring about the appropriate delivery of treatment services. This person also words directly with hospital administration to assist in creating and expending personnel budget, capital budget and current expense budgets. This person is also involved in many therapeutic processes on the unit.
4. Psychological Services are provided through the psychological discipline.
   A Psychologist is assigned (through the discipline) to Pediatric services. The primary responsibility of the Psychologist is to provide psychological assessment in contributing to the development of the treatment plan.
5. Three Clinical Social Workers who are responsible to provide social and family assessment, help create individual treatment plans, be a treatment coordinator for a caseload of patients, provide individual, family and group therapy. The Social Worker is responsible to coordinate complete discharge planning and maintain community contacts with CMHC's, Juvenile Courts, School Districts and DFS.
6. A Recreation Therapist to complete recreational assessments, help develop individual treatment plans, develop, supervise and carry out recreational programming which is goal oriented, oversee delivery of leisure time recreation, and provide for physical skill building activities.
7. One Recreation Technician whose role is to assist the Recreation Therapist as well as provide for craft room activities and supervise the use of volunteers in our program.
8. Nursing Service Personnel.
   A. A Unit Nursing Director who is responsible for coordination and supervision of all nursing service on the unit.
   B. 5 R.N.'s to provide at least one per shift on all shifts, to provide for delivery of nursing and medical services and be responsible for general patient care provided by all nursing service personnel.
   C. A Psychiatric Technician Mentor who, under the direction of the

UND, is responsibile to orient and train new psychiatric technitions. This person also coordinates inservice training.

D. 15 Psych Techs who are responsible to provide supervision and care of the patients when they are not in school. They are also required to assist in housecleaning and maintaining a warm therapeutic environment on the unit.

E. One Psych tech / Housekeeper who is designated to provide housekeeping services on the unit with training from the housekeeping department. Occasionally this person will be required to perform patient coverage duties similar to those described above.

9. A Secretary whose responsibility is to take care of all the clerical needs on the unit. Specifically, see that the patient records are complete and that unit documentation for Medicaid and JCAHO standards are being met.

10. A Unit Clerk / environmentalist. This person does filing for nursing service, coordinates all medical clinics and consultation requests. This person is also responsible to coordinate with Unit AD and hospital support services to insure that unit environment is maintained and pleasant.

11. Educational Staff.

A. Principal for Pediatric Educational Services. This person covers school administration for both Adolescent and Children's units. Also coordinates with other school at the time of admission and discharge of a patient.

B. Three special education teachers who are licensed to teach emotionally handicapped children to provide an individual educational program for each patient.

C. Three Teacher-aides to assist in providing one-to-one tutoring and classroom control.

D. A secretary to provide the same services for the school as is provided by unit secretary.

E. A part-time Speech and Hearing Therapist to evaluate speech, and hearing needs and provide corrective therapy where necessary.

RECREATION PROGRAM:

The role of play activities in the growth, developoment and education of children is of utmost importance. Through play experiences children are able to explore, experiment, observe and gain experiences that help them to learn a wide scale of values which form the basis of their thinking patterns and attitudes abut themselves, their families, their playmates and the world around them. The play experience also provides the child with valuable opportunities for constructive skill learning. Recreation therapy is an important and active treatment modality used in unit programming. The overall goal of the recreation therapy program is three fold:

1. Improve the quality of life.
2. Improve the level of social - emotional functioning.
3. Strengthen the self concept of each patient.

This is accomplished by providing positive activity experiences from which the children can grow. We work to help each child develop and improve functional behavior and healthy coping skills. We work to help each child to transfer what they learn through recreation into other aspects of their lives.

The recreation therapy program is designed to meet the physical, mental, social, and emotional needs of each patient. Programming, therefore, is based on the needs, interests, abilities, and desires of the patients. Because recreation therapy is a reality based therapy it provides valuable information in helping the staff to understand and evaluate the progress of the patients. Many of problems the patients have show up in recreation activities. It is very difficult for anyone to hide feelings, emotions and attitudes while participating in a recreational activity. There three major aspects of the recreation therapy that we emphasize in the program.

1. Therapy- In therapy we focus on modifying or eliminating dysfunctional behavior that interferes with successful participation in activities. We reinforce positive behaviors that are expressed and observed. Self concept is strengthened as cycles of failure are broken and the patients increase their ability to feel good about themselves.
2. Education- In this area we focus on teaching awareness of play and recreational opportunities, age appropriate skills, positive attitudes and social skills. We emphasize awareness, skills, and attitudes about those activities that can be done on a day to day basis at home and school.
3. Participation- In this area we provide opportunity for the patient to participate in activities of interest to them and when feasible give them the chance to choose the activity they will do. The focus on having fun and the enjoyment of participating in recreation and play activities.

Activities are adapted and modified when necessary to meet the needs of the patients and increase the chances for each child to have positive experiences. We work to carry out activities in a supportive atmosphere where effort is valued.

Almost all of our activities take place in a small group or individualized setting. This approach helps ensure a good staff / patient ratio, good supervision, and individualized attention. We do have large group activities (112 or more patients) in connection with some of our community based activities.
Listed below are some examples of specific problem areas where Recreation therapy objectives are written and included on the “ICTP”.

Low Self Esteem	Short attention span
Aggression	Poor social skills
Depression	Poor peer relationships
Impulsiveness	Anti-social behaviors
Destructiveness	Inappropriate sexual behaviors

Examples of activities that are used in the unit programming include:

Downhill skiing	Initiative games
Cross Country skiing	Bicycles
River running	Service projects
Fishing	Sports - team and individual
Camping	Crafts
Climbing	Ceramics
Hikes	Community based events
Picnics	(Bowling, Museums, Sports events,
Horseback riding	water parks ect.)

The success of the Recreational Therapy Program is very dependent on the support given by the staff. The program must have the participation of the staff in order to be highly effective.

HOME VISITS

Home visits are encouraged on the Children's Treatment Unit for several reasons. It is felt that the children need to have frequent contact with their family. The goal of the visits is for the patient to have the opportunity to interact with their family in more successful ways than prior to their admission. With frequent home visits, changes that are gradually made seem to be more acceptable and understood by parents. As parents meet with staff members, goals are set to help in the treatment at home as well as in the hospital since the children have not been successful in their homes. Home visits are also a measure of the changes the children and their families are making. Home visits are also encouraged so a child does not become institutionalized. All of the children do not have homes and families to visit. The staff will try to have these patients visit with relatives or foster homes. On occasion there might be a volunteer family involved with a particular patient.

PROCEDURE

When the children qualify for a home visit, it is approved by the "treatment coordinator" and the unit doctor after a discussion with the treatment team. Home visits are also coordinated with the parents as well as Community service caseworkers, if appropriate. When ever possible these arrangements need to be made prior to Wednesday of each week so as to give the Hospital Pharmacy time to prepare home visit medications. Home visits are written in the

Physician's Orders as well as the Progress Notes. We chart medications taken with the patient, the time they leave, who picked them up, and what they take with them. When the child returns, the time, who brings them back, what items they bring back and a brief statement regarding performance on the visit are again charted in the progress notes. A Home Visit form which contains objectives for the visit as well as a brief explanation of performance scores and a section for the family to rate the patients level of goal achievement are also included on the form.

RESIDENTIAL LIVING

The Children's Dorm, comprising most of the second floor of the Medical Surgical Building, contains living space, offices, kitchen and recreational facilities. Many of the patients have a private room. Efforts are made to have rooms and living arrangements that are cheerful, clean and homey, with the personal touch of posters, model cars and planes, radios and mementos that have special meaning to the patients.

As the patients wake up in the morning, they are helped by foster grandparents and nursing personnel to dress, take medication and clean up their personal living space. Then they go to kitchen where one of the staff or foster grandparents prepares and serves breakfast in an atmosphere that is as much like home as possible. After breakfast there is a little free time until school starts. This allows the patient time to interact with different staff members or talk with peers.

They have a 30 minute lunch break and then return to school.

When school is over the children return to the unit and have a snack and some free time before beginning their afternoon groups/activities.

Dinner is served at 5:15 p.m., after which the patients again have involvement in prescribed recreational activities or diversionary outings. They are given a time to be involved in sports, crafts, ceramics, or activities such as playing games with their own peers.

Late in the evening, the nursing staff find time to counsel with the patients, both in large groups and also individually, concerning the day's happenings. Nursing staff are assigned to each hallway so the individual time can be spent with each patient. This time can allow the patients to focus on behaviors and areas where he/she performed especially well or areas where there is need for improvement.

EDUCATION

Oak Springs School

The children participate in a public school program operated within the hospital. This educational program receives major emphasis since many mentally ill children experience learning difficulties and social-emotional problems. As a social institution, the school's role is to help the children to acquire specific academic skills and knowledge as well as appropriate social values and relationships.

Presently, there are 3 certificated teachers and 3 teachers' aides who work full time in providing instruction to the children. The educational programs and staff are supervised by a school administrator and assisted by a school secretary. All these educators work together to optimize the achievement levels of the children

by offering a nurturing, safe school climate. The salient features of this school climate include state-approved curriculum-instruction programs, high teacher expectations, maximizing positive patterns of interaction between educators and students, and fostering positive ego development and social responsibility through rewards for desirable behaviors and appropriate consequences for misbehaviors.

The teaching-learning activities of the school are geared to help each child have as many success experiences as possible. The academic programs are conducted in a relaxed, non-threatening atmosphere wherein the child's physical and social- emotional well-being are nurtured and protected as much as possible. Small group instruction and one-to-one assistance are provided as needed. A computer lab and library are extensively used to supplement and support the school's academic programs. Each child's progress in school is assessed, monitored and recorded on a regular basis.

The school personnel work closely with the hospital personnel to mobilize and coordinate their efforts and programs to benefit each child to the greatest extent possible. Together, these two institutions attempt to strike a desirable balance between the clinical/medical needs of each child with the requirements he/she has for schooling as mandated by state and federal laws.

VOLUNTEER PROGRAM

The Children's Treatment Unit does utilize help from volunteers. However, involvement is limited so as to protect the patients from being used to meet other's needs. In general patients are not allowed to have a one-to-one volunteer. Individual volunteers would be allowed only in special instances where a particular patient need was going unmet and only when the particular volunteer has been very carefully screened.

Volunteer Groups

We do like to utilize volunteer groups who can come to the unit and provide for special activities such as:

1. Groups that come and bring plays, games and decorations for holidays.
2. Groups that want to make needed Items for the unit such as quilts, Blankets, etc.
3. Groups that teach special craft skills, i.e., clay, woodwork art, leather, weaving, rug making, etc.

Volunteer Regulations

The USH Volunteer Coordinator is in charge of recruiting, training, and assigning volunteers to units. She works with the unit volunteer coordinator who is the Unit Recreation Technician.

The unit volunteer coordinator holds an in-service to orient each group to as unit policy and expectations. The Recreational Technician or nursing staff is assigned to each group to help supervise the activity. If it is an activity that requires the patients to be transported, we will furnish the van and driver to transport the patients to and from the activity.When the Recreation Technician is not on the unit the volunteer will be supervised by unit RN or a designated nursing service person.

RATIONALE

The "Redirection Program" is one of many behavioral modification techniques used on the Children's Treatment Unit. The rationale behind "Redirection" is to momentarily remove the child from the therapeutic community where he receives interaction and positive reinforcement from others to a room or place where he/she is treated neutrally. The child is removed from the community interaction when he/she is exhibiting one or more of the target behaviors, which include: Fighting, oppositional and provoking.

The patient will learn the target behaviors are not acceptable and that they receive positive reinforcement when they are not being "Redirected".

STEPS INVOLVED

It is important to remember that other options are available to be used along with or in place of the formal "Redirection" program. "Redirection" can be used when those patients who have it identified as a modality in their "ICTP" exhibit target behaviors. "Redirection" as a modality will also be addressed in the physician's orders in the individual patient's chart.

1. Identify a target behavior, i.e., f, p, o.
2. Respond neutrally -- "You need to go to Redirection."
3. Place child without verbal argument into "Redirection". It should be noted that Redirection can take place in many different locations IE; one of the couches or chairs, patient's own room, playground benches etc. If at all posible the location should be away from other patients.
4. As soon as the child calms down (minimum of two to five minutes), take him/her off of "Redirection" -- "you may come off now" -- and place him/her back into the regular programming. At this time, certain patients may want to discuss what happened and different ways they could have handled the situation which brought on the "Redirection".
5. If "Redirection" is taken in a place other than the "Redirection" area/ seclusion room, follow steps 1 through 4. If patient refuses to cooperate then go to step 5 and use the Redirection/Seclusion room. Note: Patients are not to be locked in their own rooms.
6. If a patient won't stay in "Redirection" (i.e., leaves the area/room or is out of control), then take him/her to "Redirection" room and close the door (not lock) until he/she is calm -- then open the door. If the patient will not stay in the room then go to step #9 (note: if you have to hold the door closed with your foot or arms it is the same as if the door was locked and you go to step # 9).
7. If the patient remains calm and cooperative for two to five minutes, then take him/her out. Once the episode is over inform the RN that the patient required the use of the Redirection/Seclusion Room for the "Redirection" intervention.
8. Repeat as needed.
9. If the patient refuses to stay in the "Redirection/Seclusion Room" room and it becomes necessary to lock the door you must:

a. Inform the unit RN of the situation to assess and obtain a seclusion order if necessary.

b. Treat as a seclusion -- Use "PIRS", blue note, 15 minute check.

DOCUMENTATION NEEDED

Each time a patient is placed in "Redirection", the person placing the child records the following information on a specified sheet.

date
target behavior
initials
time (in and out) of "Redirection" episode
door closed (yes or no)

The number of “Redirections” and if the door was closed or not, are also recorded daily in the progress notes by nursing staff.

STAFF REVIEW

Approximately every six months, the staff are reminded how to utilize “Redirection Program”. At this time, problems, concerns, and suggestions are also made to make the modality more effective. It is continually stressed that “Redirection” is not a punishment,--it is neutral with the goal being to return the patient to the treatment community where he/she receives positive reinforcements.

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Arthur Miller MD. Diane Maciel LCSW AD.

Protecting Patients and Staff From Harm

Philosophy:

Both patients and staff on the Children's Unit have a right to feel safe and be treated with respect. Neither patients nor staff should have to experience added feelings of fear when patient behaviors escalate and the patient needs to be restrained.

Procedure:

Our approach to a patient must take into consideration past trauma the patient has experienced. It is important that, whenever possible, our intervention does not re-enact past trauma for the patient.

These techniques are to be used in conjunction with all the verbal interventions mentioned in **USH "SIT" training.** They are to be used in place of any pressure holds except with larger patients. Use of control holds taught in hospital wide "Safety Intervention" may only occur with patients who have been approved by the Unit physician.

If you have to use a physical intervention, notify the RN. immediately. The RN has the responsibility to assign a second staff person to observe the interaction and to obtain a "Physicians" order if the hold lasts 5 minutes or longer.

Mental Checklist: As a Children's Unit staff member, when you see a need to protect a patient from his/her self or others, please consider the following:

1. Remember that our approach to a patient must
1. Will I need help from another staff member? If answer is yes then "How soon can support arrive ?"
2. If possible, remove other patients from the area. **Spectators** only serve to **increase the escalation and the likelihood of injury to patients or staff.**
3. Remember not to **personalize** patient statements or actions. If you overreact and get into a power struggle the danger level will only escalate.
4. Be as relaxed as possible (the patient will sense your non-verbal posture). Try to move with the patient, using as little force as necessary (We are not trying to win a wrestling match.) and disengage as soon as possible.
5. Remember to use **soft voice tones** and encourage the patient to demonstrate positive self control.
6. **Be honest with yourself** and acknowledge your own limitations.
7. **"SIT"** techniques are not to be used to show the patient **"Who's in Charge"**, but to **protect the patient from hurting self or others.**

Safety Intervention Techniques:

1. **One Staff management and guiding -- Standing or sitting.**
   Stand or sit to the side and behind the child. Both of your arms will be

under the child's armpits holding the arm that is to the side you are on. The other arm is allowed to stay free (see picture and video). If you are standing try to keep the child moving in the desired direction. If the patient begins to hurt him or herself or try to injure the staff person then a second staff person should hold the free arm (see "Two Staff Management"). If you are already sitting down you may cross the patient's arms and hold both of them with your hands. We are not trying to do a "basket hold" one arm is not tucked underneath the other (See pictures and video).

2. **Two Staff management and guiding -- Standing.**
One staff member does everything listed in the "standing" portion of #1. A second staff member takes hold of the child's arm opposite of where the second staff is standing (Right hand to child's left arm or left hand to child's right wrist). Staff member then places other hand on the child's hip as though giving a side hug (See pictures and Video).
3. **One Staff -- prone position:** Child should be turned on face down with his one arm across and under the upper chest.. Staff person places upper torso across child's back, with one hand on elbow of the patients arm which is across the upper chest. Staff's other arm should come under the patient's arm pit and grasp the patient's wrist. This leaves the child a free arm to move around to reduce panic of having no control. Any staff who observes should closely monitor both child and managing staff person for signs of stress or fatigue (See pictures and Video).
4. **Two or Three Staff -- Prone Position**: This technique is used if the child is trying to **kick or hurt his/her self or staff with the free arm and hand.** Use same procedure as in "One staff". Second Staff holds wrist of free arm with the arm extended away from the body. Third staff, lays on side and places shoulder and arm across Child's legs (See pictures and Video).
5. **One Staff -- Sitting Position**: Use the same technique as "One Staff Standing". If possible staff person should place back against a wall (Remember Child's arms are not crossed with one underneath resembling a basket hold). Staff member should also position him/her self so as not to be in a position to be "head butted" by the Child. While holding the patient in this manner use soft voice tones and encourage the child to gain positive self control. (See pictures and video)
6. **Two or Three Staff--Lifting and or Carrying:** From directly behind the child, staff member reaches under the arm pits (of child) and places right hand on left wrist and left hand on right wrist. If child is in a sitting position one or two staff members assist with lifting the patient to a standing position by lifting under the main staff member's arm pits and not on the child. **Staff members should be sure to use hips and knees in the lift avoiding stress on lower back.** If the child needs to be moved to another area, ie;, seclusion room, ect., the second and third staff members will put their arms around his or her knees (it is preferable that one staff wraps arm around both knees) and assist in carrying the

child (to make a smooth lift all staff members should go on the count of three.). As a staff member starts to use this procedure he/she should explain to the patient what they are going to do and the intent is protect the child from harm. (See pictures and Training Video)

SERVICE AREA

POLICY

1. Existing community services must have been exhausted and/or judged by Local Community Mental Health Center Staff to be unable to meet the current needs of the patient.
2. Patient must meet current Civil Commitment guidelines which includes evaluation by a “Neutral Detached” fact finder to determine if the patient meets commitment criteria.
3. Children who are dually diagnosed as Mentally Retarded and Mentally Ill may be appropriate for admission.. However, symptoms of mental illness must be clearly described and appear able to show improvement with psychiatric interventions. DSPD must be involved from the time of admission and must help provide both placement and follow up care for the patient once the symptoms of the mental illness are controlled.
4. Children traditionally managed by youth corrections are not appropriate unless they meet current Civil Commitment guidelines.
   4.1. Prospective patients cannot come directly to the State Hospital from a detention facility unless they are being detained while awaiting admission.
5. Children with Sexual Reactivity must also have other identifiable mental illness and must meet current Civil Commitment guidelines.
   5.1 Children with serious sexual offense histories cannot be considered for admission to the Utah State Hospital.
6. We strongly recommend family involvement and expect that families will participate in their child's treatment whenever possible.

PROCEDURE;

1. Anyone desiring to have a patient admitted to the Utah State Hospital must first contact their local Public Community Mental Center for screening.
2. If the local mental health center agrees that the criteria listed above have been met then Liaison person working for the mental health center will contact Pediatric Services personnel to arrange for admission.
3. For screening purposes a completed “Pediatric Admission” packet must be received by either the Children's or Adolescent programs’ Administrative Director.

4. A patient will not be admitted to the Pediatric Service programs without proper commitment papers.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

POLICY

1. Each patient admitted to the Children's Unit has an individualized written treatment plan which is based upon the assessments of the patient's fundamental needs.
2. The Children's Treatment Unit complies with the Utah State Hospital procedures relating to treatment plans.

PROCEDURE

1. An initial evaluation is made by the unit staff participating in the intake process. From this evaluation an interim problem list and treatment plan are established shortly after the patient is admitted to the unit.
2. An assessment is completed in each area of the patient's fundamental needs. (Physical examinations, psychiatric evaluations, psychological testing, social history, activity assessment, hearing evaluations and educational testing).
3. Clinical Staffing- This is the meeting where staff develop an individualized treatment plan for the patient. At This meeting there is a broad representation of nursing service personnel, along with representation of all disciplines and program compartments.
    - 3.1 A Treatment Coordinator has been assigned to the new patient. He is the primary presenter in the clinical staff and is the staff member responsible to see that treatment goals are accomplished and that program objectives relating to the specific patient are carried out.
    - 3.2 The patient is involved in advance of the clinical staffing by the Treatment Coordinator so that the patient knows what to expect and can help in formulating problems and goals. After an initial discussion by the staff, the patient is invited into the clinical staff meeting to participate in his evaluation and treatment planning.
    - 3.3 Problems and needs of the patient are identified and organized into a goal list providing focus and emphasis on specific areas requiring attention and specific strengths are identified.
4. 3.4 Short term objectives relating to specific problems/goals are developed to provide direction and to help determine progress and outcome. The treatment objectives are measurable and have a time expectation as to when the objectives should be accomplished.
5. 3.5 A treatment plan is defined. The plan describes specific ways in which the patient may receive help with his problems and identifies which staff member is responsible for a given area of service.
6. 3.6 The completed individualized treatment plan is comprehensive, covering most areas of the patient's fundamental needs. It involves both the patient, his family and significant others.
7. The Children's Treatment Unit complies with the Utah State Hospital procedures governing the use of seclusion and restraint.

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

The Children's Dorm, comprising most of the second floor of the Medical Surgical Building, contains living space, offices, kitchen and recreational facilities. Many of the patients have a private room. Efforts are made to have rooms and living arrangements that are cheerful, clean and homey, with the personal touch of posters, model cars and planes, radios and mementos that have special meaning to the patients.

As the patients wake up in the morning, they are helped by foster grandparents and nursing personnel to dress, take medication and clean up their personal living space. Then they go to the kitchen where one of the staff prepares and serves breakfast in an atmosphere that is as much like home as possible. After breakfast there is a little free time until school starts. This allows the patient time to interact with different staff members or talk with peers.

Lunch is served on the unit. Weather conditions and the patient's preference and needs dictate whether the noon time activities are inside or out of doors.

Dinner is served at 5:15 p.m., after which the patients again have involvemen tin prescribed recreational activities or diversionary outings. They are given a time to be involved in sports, crafts, ceramics, or activities such as playing games with their own peers.

Late in the evenings, the nursing staff find time to counsel with the patients, both in large groups and also individually, concerning the day's happenings. Nursing staff are assigned to each hallway so the individual time can be spent with each patient. This time can allow the patients to focus on behaviors and areas where he/she performed especially well or areas where there is need for improvement.

OVERCOME PHYSICAL BARRIERS

Policy

Children's unit staff shall not allow physical barriers to interfere with interaction of patients and staff.

Procedures

1. Patients may use Craft Room with any staff member under the direction of the Recreation Technician.
2. Not more than two staff members will be in Day room office at a time (except for authorized meetings, patient charting, or when the patients are not on the unit).
3. Nursing personnel will interact with the patients on the unit by making themselves available to play games, supervise T.V. and talk with the children.
4. At bedtime, a Psych Tech will be in each hall to help the patients prepare for bed.
5. Psych Techs, insofar as possible, will escort patients, who are frightened at bed time, to their rooms and provide a "listening ear" or do other things to help the patient feel comfortable.
6. Psych Techs are encouraged to have patients help with preparation of evening treats.

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

CARE OF LIVING QUARTERS:

Policy

Patients are encouraged to take responsibility for maintaining their living quarters, and self-care as is appropriate to their clinical status.

Procedures

1. The patient is responsible for care and cleanliness of their own room. With staff guidance, they are expected to make their own beds, vacuum their carpets, and straighten their rooms prior to breakfast. He/she changes his own linen once weekly unless otherwise needed.
2. Small children are encouraged to dress themselves assisted only when necessary by a psych tech or foster grandparent.
3. All children put on clean clothes daily, comb hair and brush their teeth.
4. Baths are taken by all patients daily.
5. If a bed is wet during the night, the patient will bathe, change linens, and remake the bed.
6. Each patient is responsible for clearing their dirty dishes at breakfast or emptying their trays at lunch and dinner.
7. Each patient is responsible for disposing of their dirty laundry in available hampers.
8. On occasion patients are permitted to help prepare their own breakfast with supervision. A group of patients may be assigned to a psych tech to prepare evening treats.
9. Natural consequences are used as part of the treatment program (example--if a patient marks upon a wall, he is required to wash the wall).

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

DISPLAY OF PERSONAL BELONGINGS:

Policy

Patients are allowed to display personal belongings and decorate their own room.

Procedures

1. Upon admission, patient and families are to be informed that toys and personal articles may stay with the patient but they could be broken or stolen because of the nature of other patients.
2. When conditions on the unit require extra security rooms will be locked, when the patient is not in the room, to protect his/her personal belongings.
3. The patient may display toys, handicrafts and hobbies on top of dresser, on bedside table and shelves.
4. If a patient's condition dictates, the privilege to display toys and hang pictures may be denied to him/her as a natural consequence which is part of his treatment program. This will be documented in the patient's individual treatment plan.
5. All cosmetics, lotions, and curling irons will be labeled and kept in an area outside of patient rooms.
6. Posters and pictures may be put on the walls of the patient's room.
   - 6.1 If a picture depicts violence or is lurid, (inappropriateness will be decided by at least two staff members) it will not be allowed.
   - 6.2 If the patient protests the decision, he/she may discuss the appropriateness of the picture with staff members at the next staff meeting.
7. Patients may keep their own radio, or CD/tape player in their room.
   - 7.1 All CD's and tapes will be stored in Patient's locked box near the Tech office and checked out when a patient wants to listen to them. They are to be checked back in when patient is finished listening to them. CD's and Tapes are not to remain in a patient's room overnight.
     - 7.1.1. CD's are especially vulnerable to being broken and used as an instrument to harm self or others.
     - 7.1.2. Checking these items in and out lessens the possibility of useing them for trading, or lending.
     - 7.1.3. There is a more limited opportunity for using pre-recorded cassette tapes to record inappropriate material if they are checked out and back in again.
   - 7.2 Music must not be vulgar. If staff feel that tapes are inappropriate to age and treatment of the patient, the items must be returned home.
   - 7.3 The patient may discuss the appropriateness of his/her music with staff members at change of shift meeting.
   - 7.4 Volume must be kept at a level which does not disturb others.
   - 7.5 Music must be turned off at bedtime unless otherwise determined by staff members.

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

The Children's Treatment Unit complies with the Utah State Hospital referral policies.

Procedures

1. Referrals within the institution--The Children's Treatment Unit is responsible for handling referrals and admissions when the prospective patient is between 6 and 13 years of age. There are occasions, particularly with older and more mature children, when the person being referred is clearly more appropriate for the Adolescent Treatment Unit. When this occurs, the Administrative and Clinical Directors of both units along with appropriate clinical personnel will be involved in assessing the patient's needs and making the placement.
    1.1 In rare instances a patient in the Children's program may exhibit behavior that is extreme or dangerous to a degree that remaining on the unit poses a serious threat to the other patients. In such a case a referral can be made to the Adolescent or Adult requesting temporary security guesting or a transfer. The procedure is the same as described in section 1. In case of a transfer there would be a discussion followed by a formal staffing where all aspects of the situation would be considered. The Adolescent or Adult units may then reject or accept accordingly. In case the two units were unable to agree on disposition, the Hospital Clinical Director would make the final decision.
2. Continuity of Care--The Mental Health Policy in the state requires that all patients with the state's public mental health system must be admitted to the system by the appropriate Community Mental Health Center. When it is determined that less restrictive alternatives cannot adequately treat or meet the needs of the patient, admission to the Children's Treatment Unit is arranged between the referring center and the Children's Unit.
    2.1 In addition the mental health center several other agencies or professionals have typically been involved with the patient and his family. It is our practice and policy to maintain contact and communication between our staff and community service providers during the patient's hospitalization so that relationships are maintained and continuity of care preserved.
3. Community contacts--Monthly visits are scheduled with mental health centers, juvenile courts and other agencies in the larger populated areas of the state to screen new referrals, review progress of patients and join in discharge planning. The on going communication and continued relationship between agencies insures consistent attention to patient needs before, during and after hospital treatment.
4. Specialized Community Services--Patient needs are largely met by use of the services and resources existing at the State Hospital. Referrals

for consultation, treatment or evaluation to service providers in the community are occasionally necessary. Some examples of services which are not covered at the hospital are: Major surgery, Internal medicine, and Legal services. In every case appropriate referral information will be provided to assure proper continuity of care for the patient.

5. Assigned Responsibility--A treatment coordinator is assigned to each patient shortly after admission to the unit. This staff member has specific responsibility to monitor program, guide and serve the patient throughout his/her stay in the program. If a referral to another services is required the treatment coordinator is responsible for following through.
6. Case Record Documentation--The documentation regarding referrals will be found in the patients "blue" progress notes and in the physicians orders.
7. Confidentiality--Care will be taken to make certain that the patients' rights are protected in regard to the confidentiality of the patient record. Referral data will not be sent unless a release of information form is completed by the legal guardian.

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy: It is the policy and program of the Children's Unit to maintain a dog to be used as a therapeutic tool in treating the patients**.**

Procedure:

1. The puppy will go to a licensed vet for the series of puppy vaccinations as well as health check-ups. This series will include rabies vaccinations.
2. The vet of choice will be Dr. Pew
   @ Utah Valley Vet Hospital
   525 S. State St.
   Orem, UT
   This office works with a P.O. and can be used on a 24 hour emergency, as well. Two numbers are available: 225-5395 and 379-3258
3. The puppy will also be spayed or neutered at the earliest possible age, as determined by the vet.
4. The dog will go in every year for a check-up at the vet to assure health and remain current on vaccinations, including rabies every other year.
5. The dog needs to consistently wear a collar with the rabies vaccination tag as well as an identification tag with name, address, and phone number.
6. The unit has constructed a kennel where the dog can be placed at times when the dog needs to rest or cannot be supervised by staff. The kennel is a cement pad that is fenced with a gate, and has a dog house with pad and blanket. Some toys should be kept in the kennel.
7. The dog should remain on the unit where the children and staff can interact with it for the larger part of the day. Since this is a Therapy Dog, a lot of human contact is essential. There are areas that the dog should not be allowed to enter. The dog is never allowed in the kitchen area at all. The dog should only be allowed down the hallways or into the children's rooms with direct staff supervision. The dog should remain in the dayroom for the most part.
8. Feeding
   A. The dog food of choice is Science Diet. The food is stored in a large drum with a latch-on lid located out on the dock.
   B. Puppy: We use Growth Formula until age 1 and 1/2 years
      1. Four meals per day until age three months.
      2. Three meals per day until age six months.
      3. Two meals per day above age six months.
   C. Adult: We use Canine Maintenance.
      We use the "Free Choice" method which is leaving fresh food and water down all day. (If the dog develops obesity, the food may be limited to two meals per day.) The food and water on the unit need to be refilled and refreshed twice a day (0700 and 1400), or as necessary.
   D. Chocolate is toxic to dogs. It causes vomiting, diarrhea, seizures, and can be fatal.

E. The dog should not be fed "people food" by either staff or children (this includes any food, even meat, cheese, bread, sweets, etc.). The dog comes into contact with far too many people for each person to give "Just a little bit." A consistent diet helps the dog remain healthy.

F. A good treat to feed the dog is ice. They enjoy chewing and there is no limit. Dog treats are stored in a box (with the children's boxes) and should be checked off on the schedule posted near the box. The treats should be limited to four per day as monitored by the schedule.

G. We have established an account with Petsmart on 7200nd South in Salt Lake City. They accept Purchase Orders for food and supplies (treats, leash, collar, toys, shampoo, vitamins, etc.)

9. Potty Breaks

A. Puppy: Puppies need to eliminate after:
-eating, drinking, sleeping and playing. Puppies should be offered breaks after each of these events and whenever observed sniffing around, looking for a spot.

B. Adult: Dogs that are housebroken need a loose schedule for potty breaks, depending on the individual dog. (For Jessie: Approx 0630-0770, 1000-1130, 1400-1600, 1700- 1900, and 2200).

C. The dog should be taken for potty breaks an the southeast lawn. Each time the dog leaves a deposit on the lawn, this needs to be cleaned immediately. There is a pitcher and scoop for this purpose located near the kennel.

D. If the dog has an accident on the unit, a "gentle" scolding is in order. The dog is taken outside where it will be "praised". The soiled area needs to be cleaned with Liquid Alive, located in the locked cabinet.

10. General Information

A. While walking the dog (daily), a leash will be used at all times while out on hospital grounds. One exception is when the children are playing on the playground, only if she can be closely watched and is trained to stay with the group.

B. Leash laws will be strictly adhered to while off the hospital grounds.

C. There will be periodic inservice trainings for staff to address current issues surrounding care and training.

D. The staff that are orienting a new patient to the unit also orient the new patient to the unit Therapy Dog.

E. The dog will receive some basic training. Commands such as: "sit"; "down"; "stay"; "drop it"; "come"; and "heel"; will be included. One person may initiate these commands, but once the dog becomes familiar anyone can give the commands and the dog will be expected to obey. The method for training (as well as housebreaking) will be positive with rewards for good behavior as well as gentle scolding for bad behavior. At no time should anyone

physically strike the dog. For example, if the puppy chews on something that belongs to the unit or a child, you can say "no" or "drop it" at the same time that you are removing the object, and then replace the object with one of the dog's toys.

F. The dog will be bathed every two weeks. This should be done with at least one child present, in an effort to teach the child some responsibility and how to care for the dog.

G. The dog should have her teeth brushed a minimum of once a week, but every day would be good. A child can be involved in this as well.

11. Since this is a Therapy Dog, she should be included in activities whenever appropriate and coverage is good. For example: going out on the grounds, going to parks, van rides, winter camps, and summer camps including river runs.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy

1. The Children's Treatment Unit complies with the Utah State Hospital personnel policies and procedures as found in the USH-OPP Manual.
2. There is a job description written for each staff member on the unit. A statement of duties and responsibilities is attached to the performance appraisal which is completed annually while progress will be reviewed quarterly or more often as needed. There is also a copy of the individual job description on file in the Unit Guideline Manual.

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

It is the policy of the Children's Treatment Unit to see that funds in personal accounts are spent only for personal needs of the patient. They are not to be spent on items that are used by all of the unit.

Procedures

1. Money request forms will be recorded in a unit log.
2. Receipts for merchandise will be kept with the entry in the log.
3. Any money left over from purchase will be placed in the Patient's money envelope kept in the nurses station.

APPROVED:

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Unit Administrative Director Date

_____

Unit Clinical Director Date

Policy

1. The Children's Treatment Unit maintains a written patient record for each patient.
2. The Children's Treatment Unit complies with the Utah State Hospital Patient Record Department policies and procedures as identified in the USHS-Opp Manual.
3. The Children's Treatment Unit recognizes the patient record is confidential and complies with the Utah State Hospital statement on Confidentiality of Patient Records.

Procedures

1. A permanent record is kept on file at the Children's Unit for all patient in residence. The permanent record has all of the pertinent information relating to admission, medical tests, progress notes, individualized treatment plan, letters other documents and discharge information. When a patient is discharged, his permanent record is sent to the main record room for filing.
2. An educational chart is also maintained as part of the school program. All of the significant educational information is organized in this folder and kept on file at the Children's School.

APPROVED:

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Unit Nursing Director Date

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

1. The Children's Treatment Unit complies with the Utah State Hospital Policies and Procedures as found in the USH-OPP Manual.
2. The program does utilize kitchen space on the unit to prepare and serve the breakfast meal, special occasion lunches and dinners, and evening snacks. Lunch and Supper are prepared by hospital food service and brought to the unit to be served. It is our desire to have the maximum amount of home like atmosphere.

Procedures

1. Food is prepared every week day morning by Foster Grandmothers.
   - 1.1 Children are encouraged to take care of personal grooming prior to coming to the breakfast area.
   - 1.2 The patients select from the menu what they want, the quantity (within reasonable limits) and how they want it prepared.
2. On weekends or evenings the food is prepared by the staff and patients. Care is taken to see that proper hygiene is maintained.
   - 2.1 Snacks are prepared and served in the afternoons and before bedtime.
   - 2.2 On special occasions, i.e., birthdays, etc., staff prepare special treats and meals.
3. Lunches and evening meals are prepared by food service and brought to the unit to be served. Whenever possible staff are urged to serve food "Family Style."

APPROVED:

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Unit Nursing Director Date

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

1. **ADMISSION CRITERIA:**

1.1 Boys and girls between six and thirteen years of age who are residents of the State of Utah may be admitted to the Children's Treatment Unit.

1.2 The primary responsibility of the Children's Treatment Unit is to provide treatment for the mentally ill and seriously disturbed child.

1.3 We feel a responsibility to provide a treatment program for children who have severe problems adjusting or finding success in the community. Some have a history of abuse (physical and sexual), deprivation and neglect. Some have learning disabilities or minimal brain dysfunction which limits academic achievement. Many of these young people are hyperactive, overly aggressive and under socialized.

1.4 A requirement for admission to the Unit is that community resources have been exhausted. The term exhausted in this instance means that a child has either been tried in a community resource or it is the judgment of agency professionals that less restrictive resources would be inappropriate.

1.5 We like to be of assistance in the evaluation and treatment of children who manifest delinquent, social or behavioral problems when able to do so. Admission to the program for these type patients is dependent upon bed space, program pressures and individual motivation. Program and environmental limitations prevent us from providing security and treatment for the more dangerous and aggressive patients. In order for the program to remain effective, we must maintain screening prerogatives.

1.6 The Children's Treatment Unit is not intended to meet the needs of the mentally deficient youngsters. However, at times we are requested to try and determine how much effect apparent emotional disturbance is having on a child who appears to be mentally retarded.

PROCEDURES:

1. ADMISSION PROCESS:

1.1 Upon request for admittance to the Children's Treatment Unit an admission appointment will be set up. This conference will be held at the Children's Unit. The appointment should be confirmed by the parent or guardian of the patient. Prior to this, the mental health center and other agencies involved should send pertinent psychiatric, social, psychological, medical and school information which will assist the Unit staff in arriving at a decision of whether or not to admit the patient.

1.2 The prospective patient, his/her parents, guardian and the professional person responsible for the referral (if possible) will

meet the hospital and school personnel during the admission evaluation. The members of this admission team are: Psychiatrist, Social Worker, Psychologist, R.N. and School Principal. They interview both the patient and parents to obtain first hand data. A brief conference will follow these interviews, at which time an interpretation of the findings and the recommendations will be shared with those in attendance.

1.3 Sufficient information is collected during the intake process so that an initial treatment plan can be developed on the day of admission.

1.4 If the child is accepted, he/she may be admitted the same day. The parents, therefore, should be advised of this possibility and come prepared to leave the child should he/she be accepted into the program. If the child is not accepted, an explanation will be given to the child and family and a letter sent, to the referring agency or professional, documenting the reasons why the child was not admitted.

2. TYPES OF ADMISSION:

2.1 Voluntary Admission--The state law allows parents or legal guardians to admit their children on a voluntary basis, as long as an independent examiner determines that the criteria of the Child Committment law is met. Under this procedure, parents may ask for the release of their child whenever they wish.

2.2 Juvenile Court Commitments and Evaluations--In some cases, children admitted to the hospital are committed by the Juvenile Court for evaluation and treatment. Periodic hearings are held to evaluate progress and determine future plans. A report is sent to the court by the Unit staff indicating progress and making recommendations. Even in the cases where this procedure is used, the staff feel it is crucial to go through the admission and screening process previously described.

3. ORIENTATION PROCEDURES FOR NEW PATIENTS:

Orientation, by community professionals acquainted with the Children's Treatment Unit, often begins before a patient is admitted to the program. Parents or legal guardians are encouraged to visit the program and become acquainted before the admission conference and to be present at the time of intake to facilitate open, two-way understanding of the program and the patient. Program compartments, Unit and Hospital policies and basic legal rights are explained to both the patient and parents. Parents are required to be involved in family therapy whenever possible and this expectation is made clear during the orientation period. A tour of the facility is conducted to acquaint the patient and family with the various education, recreation, living and treatment compartments. Nursing care staff check the patient into the dorm, identify belongings, and assign a room. In most instances the child will have his own room or share with two other patients.

The new patient is soon greeted by other patients who explain both the

formal and informal structures of the unit.
Within 24 hours one of the staff will review with the patient his/her legal rights and answer any questions.

APPROVED:

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Unit Nursing Director (Date)

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy

Patients should have (on unit) visits from appropriate family and significant others.

Procedure

1. Visiting hours are from 3:00 pm to 9:00 pm weekdays and 9:00 am to 9:00 pm on weekends. Visiting at other times can be arranged by calling patient's "treatment coordinator" and letting staff know the circumstances and when the visit is desired.
2. Visitors can include family members, clergy, mental health workers, approved friends and approved volunteers.
3. Since treatment activities are often scheduled that interfere with visits, it is prudent to contact the unit or patient's "treatment coordinator" and make arrangements when a visit is desired.
4. Authorized visitors will be listed in the patient record. Restrictions on visits by authorized people must be delineated and backed up by a "Physicians Order" in the individual patient's chart.
5. Visitors are encouraged to check in with the switch board operator in the administration building. The operator will alert the unit that a visitor is coming. Visitors should then check with unit staff before seeing the patient.
6. Visitors may bring gifts for patients (please check with staff before giving). Valuable items are discouraged.
7. Treats and snacks are allowed but should be cleared with staff in advance.

APPROVED:

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Unit Administrative Director (Date)

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Unit Nursing Director (Date)

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POLICY

Home visits are encouraged on the Children's Treatment Unit for several reasons. It is felt that the children need to have frequent contact with their family. The goal of the visits is for the patient to have the opportunity to interact with their family in more successful ways than prior to their admission. With frequent home visits, changes that are gradually made seem to be more acceptable and understood by parents. As parents meet with staff members, goals are set to help in the treatment at home as well as in the hospital since the children have not been successful in their homes. Home visits are also a measure of the changes the children and their families are making. Home visits are also encouraged so a child does not become institutionalized. All of the children do not have homes and families to visit. The staff will try to have these patients visit

with relatives or foster homes. On occasion there might be a volunteer family involved with a particular patient.

PROCEDURE

1. When the children qualify for a home visit, it is approved by the "treatment coordinator" and the unit doctor after a discussion with the treatment team.
2. Home visits are also coordinated with the parents as well as Community service caseworkers, if appropriate.
3. When ever possible these arrangements need to be made prior to Wednesday of each week so as to give the Hospital Pharmacy time to prepare home visit medications.
4. Home visits are written in the Physician's Orders as well as the Progress Notes.
5. When the Patient leaves for the home visit:
   - 5.1 We chart medications taken with the patient, the time they leave, who picked them up, and what they take with them.
   - 5.2. A multi copy Home Visit is prepared by the Patient and his/her therapist. This form contains objectives for the visit as well as a brief explanation of performance scores and a section for the family to rate the patients level of goal achievement are also included on the form.
6. When the patient returns:
   - 6.1 Parents and others should be encouraged by therapists to have taken care of their "good by's" outside of the doors entering the unit.
     - 6.1.1 A nursing service person welcomes the patient to the unit.
     - 6.1.2 Parents, family members, and Guardians are encouraged to go to a designated waiting area where a RN (or designee) gets both a verbal report of the visit and a copy of the completed "Home Visit" form.
   - **6.2 The patient's belongings are to be placed in the Unit Clerk's office to be checked in by both the patient and Nursing Service staff.**
     - **6.2.1 This review of patient's belongings should occur at a time when outside distractions are at a minimum (to decrease the opportunity for the patient to bring contraband back to the Unit).**
     - **6.2.2 Any contraband should be place in a container and given to the patient's therapist so that a discussion of how it was obtained and possible plans for use of the item or items and proper return to the original owner.**
     - **6.2.3 New personal Items such as clothing or toys should be marked and recorded on the Patient Possesions Record.**
7. Nursing service personell chart the time of return, who returned the patient, and a brief statement regarding patient performance while on the visit.

APPROVED:

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Unit Administrative Director (Date)

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Unit Nursing Director (Date)

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Unit Clinical Director (Date)

On all patient activities safety must be the # 1 consideration by the staff who are planning and participating in that particular treatment opportunity. Patients cannot move toward improvement in their mental functioning unless they can feel safe while participating in therapeutic activities. (It should be noted that an off unit activity cannot be therapeutic unless it provides for safety and protection.) The patients in our care must be able to be protected from acts aggression both from self and others (Emotional, Physical or Sexual).

1. Safety on a patient activity is the responsibility of All Staff. The accountability for safety on the activity rests with the Recreation Therapist, Administrative Dir. and the RN.
    - 1.1. Failure to complete safety / supervision assignments could result in corrective action and possible termination of employment.
    - 1.2. Communication is essential to maintain a safe activity. Every activity should have a basic plan which includes:
        - 1.2.1. Objectives for the activity. The nature of the activity must be designed for the patient's benefit.
        - 1.2.2. Possible safety concerns.
        - 1.2.3. Any special nursing care issues such as meds, sunscreen, etc.
        - 1.2.4. Transportation needs and unit coverage..
2. Patient Supervision while on an activity. **SUPERVISION OF THE PATIENTS IS THE RESPONSIBILITY OF THE STAFF. IT IS NOT THE PATIENT'S RESPONSIBILITY TO MAKE SURE SUPERVISION TAKES PLACE.**
    - 2.1. Staff must have visual contact with all patients participating in the activity all of the time.
    - 2.2. Use of restrooms must be supervised. Whenever possible only one patient in the restroom at one time.
    - 2.3. If a patient activity occurs in a public venue attention to supervision must be increased.
        - 2.3.1. On most activities at a public venue the staff to patient ratio should not exceed 1 to 2. Changes from this ration should only happen at the direction of the person in charge of the activity.

Procedure:

1. RT person or Lead RN will make supervisory assignments during "Activity Briefing" just prior to the activity.
   - 1.1. RT person , Lead RN or designee will monitor to see that assignments are being carried out. Any problems noted in the supervisory process must be reported to the UND and AD.
   - 1.2. Types of assignments:
     - 1.2.1. Seating in the transportation Vehicle.
     - 1.2.2. Specific patient to be supervised.
     - 1.2.3. Specific responsibilities for achieving the objectives of the activity.
2. One of the staff will do a "Patient Roll Check" every 15 min.
3. **Protocol for traveling in vehicles:**
   - 3.1. Whenever possible staff should be involved and interacting with the patients. Patients are less prone to acting out when they are involved in meaningful activity.
     - 3.1.1 Staff should space themselves throughout the vehicle in order to be able to intervene before incidents can escalate to a point where passenger safety is compromised.
     - 3.1.2. Special care should be taken to identify potential conflicts between patients and adjust seat assignments to prevent problems from occurring.
   - 3.2. Patients should not be allowed in vehicles without staff supervision.
   - 3.3 **A staff person should be the first to exit the vehicle.** Our patients can be extremely impulsive and distractible and thus need adult supervision as soon as they exit the vehicle.
4. While on the activity :
   - 4.1. Staff are to stay with their assigned patients unless some type of emergency situation develops. When a staff person is required to assist another, the patients for which he/she is responsible must be handed off to another another staff person.
   - 4.2. Redirection can occur on an activity if necessary. Selection of possible sites (for redirection) in advance would be helpful but not always possible.
   - 4.3 While participating in the activity, staff are to be "role models" of positive interactions and demonstrate functional problem solving skills.
5. When activity is completed:
   - 5.1. Check patient roll to make sure all patients are accounted for.

5.2. If vehicle was used, follow 3.3. above.
5.3. Patients are not allowed to enter the unit ahead of staff.
5.3.1. All patients need to be checked for contraband prior to re-entering the unit.
5.4. Documentation of the activity should take place as soon as possible.
5.4.1. Verbal report of the activity should be given to the RN

APPROVED:

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Unit Nursing Director (Date)

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Unit Administrative Director (Date)

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Patients cannot move toward improvement in their mental functioning unless they can feel safe in the therapeutic environment (It should be noted that an environment cannot be therapeutic unless it provides for safety and protection.. The patients in our care must be able to be protected from acts aggression both from self and others (Emotional, Physical or Sexual).

1. Safety on the Unit is the responsibility of All Staff. The accountability for safety on the Unit rests with the RN.
1.1. Failure to complete safety / supervision assignments could result in corrective action and possible termination of employment.
1.2. Communication is essential to maintain a safe environment. All nursing service personnel are expected to be on time and attend change of shift meetings (Unless assigned to a security hall watch). Security information will be a permanent part of the "Change of Shift" agenda.
2. Patients are not to be in the Hallways or bedrooms without supervision.
2.1. Patients' rooms are to be kept locked when not in use (IE, patient in school, or off on activity) or if there is a need for heightened security on the unit.
2.2. Use of restrooms must be supervised. Whenever possible only one patient in restroom at a one time.
2.2.1 Restrooms can be left open except in the following instances:
A. There is insufficient staff to monitor hallways and restroom use. At this time patients will have to ask permission to use restroom. Staff must respond as quickly as possible.
B. When any patient is demonstrating signs of a high potential for "Sexually Reactive", or physically abusive behavior.
2.3. Patients must be checked every few minutes when taking

baths or showers.

2.4. All patient activities in Hallways must be supervised.

3. "DOS" , "One to One" and any other supervisory status are the responsibility of the assigned staff and not the patient.
4. All staff should "checkoff" the roll boards before taking a patient or patients off the unit.
5. All patients who are at risk for self harm or AWOL, must be supervised by an adult while going and coming from school or other activities.

Procedure:

1. Lead RN will make supervisory assignments during "Change of Shift" meeting.
    1.1. Lead RN will monitor to see that assignments are being carried out. Any problems noted in the monitoring process must be reported to the UND.
    1.2. Types of assignments:
        1.2.1. During Quiet time and Bed time, a nursing staff person to be in the hallways providing direct supervision.
        1.2.2. "DOS". Assigned staff must have patient in line of sight at all times.
        1.2.3. "One to One". Assigned Staff must have Patient within 10 feet at all times.
2. A nursing service person from the exiting staff will join with a nursing service person from on coming staff to do a "Patient Roll Check".
3. Whenever possible all staff should be involved and interacting with the patients.
    3.1. Patients are less prone to acting out when they are involved in meaningful activity.
        3.1.1 Lead RN is responsible to see that unit afternoon, evening and weekend activity plans are being implemented. Results of the programing must be reported to the Unit "SMT".
    3.2. Patient "Free Play" or other activities should be structured in such a way as to make the patients visible to staff at all times.
    3.3 All staff need to be alert to signs of possible safety problems before they develop.
    3.4. All staff need to be familiar with and follow unit policy regarding "Staff Interaction to Overcome Physical Barriers".
4. All patients going or coming from school or other activities must be supervised.
    4.1. A unit staff person should always be in the stair well when patients are going or coming from school or other activity.

4.2. Any patient, who has to be removed from the "School Setting" because of disruptive behavior, is to be escorted back to the unit by a **Hospital** or **Educational** staff person.

APPROVED:

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Unit Nursing Director (Date)

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

It is the policy of the Children' Unit to provide pro social entertainment for the patients. The choice of programming must reflect an understanding of the therapeutic needs of the patients. There must also be an understanding that programming that might be appropriate in many homes would not be appropriate for our patients because of past events in their lives, limited ability to control impulses, impaired discernment of reality and potential for extreme aggressive acts in the future.

Procedure:

1. Use or Pre Recorded Videos.
   - A. Videos in the Unit Collection are considered appropriate for most occasions.
   - B. Videos rented from local vendors must have a "G" rating and used with approval of RN.
   - C. 1. Only "G" rated videos may be checked out from the "Hospital Library".
     2. Unit staff are responsible to monitor patients while at the library.
     3. Items brought from the "Hospital Library" must be checked in through the RN on duty, before they can be used by the patients.
   - D. Use of other video materials for therapeutic sessions or groups must be approved by the Unit SMT.
   - E. "PG" movies must be approved by Unit SMT prior to being viewed by patients.
2. General Television Programming.
   - A. All programing must be screened for violent content. This is especially true of many of the morning and weekend children's programming.
   - B. Programming that is sexually explicit or has strong sexual innuendo

is not appropriate.

C. Programming that has themes of physical or sexual abuse is not appropriate for general viewing. There may be some instances where professionally supervised processing with the patients about the contents of some programs may be appropriate.

D. Sporting Events which focus on individualized violence are not appropriate (Ex. Professional Wrestling and any kind of boxing or Martial Arts matches.)

E. "Horror" movies and those with negative themes from the "Occult", slong with "Dark Side" Witches and Ghosts are not appropriate.

3. Recorded music and Radio.

A. Any Music or other audio programming which encourages violence against self or others is not appropriate.

B. Any Music or other Audio which has "Foul" language, sexual innuendo, or anti-social themes is not appropriate.

C. Volume of audio programming should be kept low enough so not to disturb others.

APPROVED:

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Unit Nursing Director Date

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy:

The Children's Unit encourages the use of the Patient Library here at the hospital.

Procedure:

1. Only "G" rated videos may be checked out from the "Hospital Library".
2. Recorded music, audio tapes and printed material.

A. Any Music or other audio programming which encourages violence against self or others is not appropriate and should not be checked our of the library.

B. Printed material must adhere to the same standards as video or audio materials.

C. All materials should be screened for material which might negatively impact a patient's emotional status.

3. Video games with violent nature are not to be played at the library.
4. Unit staff are responsible to monitor patients while at the library.
5. Items brought from the "Hospital Library" must be checked in through the RN on duty, before they can be used by the patients.

APPROVED:

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Unit Nursing Directtor Date

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

Use of the Internet with patients is appropriate both for increasing knowledge as well as building a stronger relationship with the staff on the Unit.

Procedure

1. Whenever possible the staff person should not work with more than two patients at a time.
2. Remember that at all times the staff person is the one in charge and responsible to use appropriate judgment as to the sights viewed over the "net".
   - 2.1. Web sites depicting violence or sexual content are not appropriate for our patients.
   - 2.2. Under no circumstances are the patients to be allowed to open "Chat" rooms.
3. Nothing can be ordered using a patient's full name (because of Confidentiality issues).
4. All copy rights must be honored. It is very important when staff are being role models for the patients' that they maintain the highest standards of ethical behavior.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

PROCEDURE

1. The Children's Treatment Unit does have a written plan which clearly delineates the number and qualifications of its clinical, administrative and support personnel as determined by the size of the program, the clinical characteristics of the patient population and the fundamental needs of the patients.
2. The Director of Education is hired by and responsive to the Provo Board of Education. The education staff are all hired by the school district and are accountable to the Director of Education.
3. The unit has sufficient R.N. and Psych Tech coverage to adequately cover all shifts, 24 hours a day and 7 days a week

APPROVED:

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Unit Administrative Director Date

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Unit Clinical Director Date

Policy

Except in special circumstances patients on the Children's Treatment Unit" are not to be on grounds without an adult escort.

Procedure

1. Passes will be granted if a patient has an "industrial" assignment or special assignment from staff to run a specific errand and on rare occasions escorting another patient to an activity on another part of the hospital campus.
2. Patients who can have a pass will have to be cleared by unit "Clinical Team". Patients on "performance levels" 1 and 2 will not be allowed a pass.
3. Hospital color coded passes (White for industrial assignments and Red for escort) are the only ones which will be used. The pass will be obtained from RN on duty.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy

The establishment of rules for patient behavior must be completed in a fair and consistent manner.

Procedure

1. Arbitrary rules made by one individual are discouraged. Ideas for new rules should be discussed with team members at a "Change of Shift" or other staff meeting.
2. In the process of creating a new rule special care should be taken to evaluate how it can be applied by other shifts or programming personnel.
3. Once the idea for a rule has been discussed with fellow team members it must then be presented in "**S**ervice **M**anagementl **T**eam" meeting for review. This review will evaluate if the proposed rule fits with unit philosophy and procedures. It will also look at the "clinical" impact on specific patients and families. If the rule is approved by the "**SMT**" team, which includes the Unit Clinical Director and Administrative Director, it will be presented at all unit staff meetings with a week's time.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy

Discharge planning is an essential element of patient care and begins at the time of the admitting process.

Procedure

1. At the time a referral is received from the Community Mental Health Center or Juvenile Court the referring party is asked to evaluate what will happen to the patient once he/she leaves our program.
2. During the "Admission Interview" plans for discharge are discussed. Important issues to consider are: Where and with whom will the patient live; Who will provide continuing care; What type of educational program will be needed.
3. Discharge planning will be addressed and reviewed in the patient's "ICTP".
4. Regular contact (usually at least monthly) will be maintained with the Community Mental Health Center who will be coordinating post hospital care.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy

The Children's Treatment Unit will attempt to expeditiously resolve conflicts as they arise. It is stressed, that if at all possible, we desire to work out conflicts so they do not create a hindrance to positive patient care.

Procedure

1. Patient conflict. When a patient has a suggestion or grievance he/she can pursue the following:
   - 1.1 Present suggestion in patient community meeting. In "community" the patient can get feedback from peers and staff who are attending the meeting.
   - 1.2 Talk with "Treatment Coordinator" about the problem and ask that it be discussed with all staff including the Unit A.D. and Clinical Director. "Treatment Coordinator" will then discuss with the patient the decision of the treatment team.
   - 1.3 Present suggestion/problem to Administrative Director or Clinical Director of the unit.
   - 1.4 Utilize "Patient Grievance Program" outlined in USHOPP manual "Patient Rights" chapter.
2. Parent and/or guardian conflict. Conflicts with parent's or guardians should be handled in the following manner:
   - 2.1 The issue should be referred immediately to the RN in charge of the shift. Most conflicts are a result of misunderstandings and can be resolved at this level.
   - 2.2 If resolution cannot occur at 2.1 then parent/guardian should be referred to the patient's "Treatment Coordinator". The Treatment Coordinator will try to bring about understanding on both sides. If necessary he/she will present the situation to the "Clinical Team", which includes the Unit Clinical Director, for suggestions of a possible resolution to the problem.
   - 2.3 The parent/guardian will also be encouraged to talk directly with Unit AD and Clinical Director.
   - 2.4 If no resolution has occurred to this point the parent/guardian will be referred to the "Hospital Clinical Director" and "Superintendent". The final authority for admission, treatment, and discharge issues rests with these two individuals.
3. Options available. If resolution to the conflict cannot be found the following may occur:
   - 3.1 If patient was admitted as "Voluntary by Parent/Guardian" then the parent/guardian may choose to remove the patient from the hospital. This discharge can either be "Approved" or "Against Medical Advice".
   - 3.2 If the patient was committed by the Juvenile Court the parent/guardian may request a hearing to convince the court that the patient should be discharged.

3.3 If option 3.1 is chosen and the unit "Clinical Team" feels that the patient presents a clear danger to his/her self or the community a petition for a commitment hearing can be filed with the Juvenile court.

APPROVED:

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Unit Administrative Director (Date)

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Unit Clinical Director (Date)

Policy: It is the policy of the Pediatric Unit to insure the adequate safety of it's patients and staff through the prevention of contraband entering the unit or being in the possession of patients not cleared for such items.

Definition: Contraband shall be defined as: (1) Anything currently outlined by the program that a patient is restricted from or not cleared to possess according to their level in the treatment program or outlined in the physician's orders; (2) Any sharp objects, weapons, or potential weapons, i.e., knives, glass, shanks, nails, razors, files, tools, personally designed weapons; (3) Illicit drugs, alcohol, over-the-counter medications, medications absconded during medication time; (4) All food items with the exception of small amounts of hard candy; (5) Caustics and other potentially harmful substances (these may be checked out for cleaning purposes with staff supervision except for the M-35 toilet bowl cleaner); (6) Perfumes, colognes, or other items containing alcohol (patients who own such items must keep them locked in valuables lock-up). (7) Personal hygiene items not cleared by staff. (8) Other items currently outlined by policy in the Pediatric Unit Policy and Procedure Manual (refer to policies regarding: radios, pictures, etc.).

Training: It is the responsibility of the Unit Inservice Coordinator or his/her designee to insure that all staff members are adequately trained in the process of searches of person and property.

1. Procedure: Unit Wide Searches

1.1 The staff will make regular assessments of the unit (at least monthly) and determine the need of a unit wide search or a search of the Boys, Girls, or Children Dorms separately. They will make this decision based on the following criteria:

a. Once every two months.
b. Suspicion of contraband noted by reports of patients.
c. History of such a problem noted in the assessments made by the staff which would indicate a problem with contraband could be occurring.
d. Any breakdown of unit security that might indicate vulnerability to contraband.

1.2 The Clinical Director, Administrative Director, Supervising RN, or unit shift RN must give the final directive to do a unit shakedown.

1.2.2 The shift RN will be responsible and in charge of the shakedown or may delegate this responsibility to another nursing service person.

1.2.3 The staff, under the direction of the RN or designee, will organize themselves in such a manner as to make assignments for all staff members involved. The assignments will include: those assigned in groups of 2 to do the shakedown; adequate staff to stay with and monitor the patients; someone assigned to monitor, label and correctly place all contraband confiscated; and a clean-up

crew who will be responsible to make sure all patient items are properly placed, garbage picked up, and beds made whenever possible.

1.2.4 The staff will meet before the search procedure begins to insure that: all are aware of their assignments; all staff member doing the actual shakedown have been oriented to the search process; a plan is devised on how to complete the search; where and how to manage the patients; and to plan a post-mortem to evaluate the process after completion.

1.2.5 All staff members participating in the shakedown will wear gloves.

1.2.6 All contraband confiscated will be recorded in the patient's chart by the person assigned to the personal items. If it is property of the patient it shall be labeled and locked in the patient's valuables area. A list will be made of the things taken so patients and staff can be informed. Food items considered contraband will be thrown away.

1.2.7 A patient representative will be assigned with the search team as a liaison for the other patients. The liaison is a representative for the patients insuring that patient property is handled appropriately. Any problem will be reported to the person in charge of the search. The Clinical Director or Administrative Director can give a waiver for this if indicated for security reasons.

1.2.8 Patients' belongings will be treated with the utmost of care and respect. The Pediatric Unit Staff doing the search will be responsible for any loss or breakage of patient items or any mishap to patient belongings due to poor handling or care.

2.0 <u>Procedure:</u> Search of Patient Personal Area

2.1 If at any time the staff assess that an individual patient or group of patients meet the search criteria in 1.0 a search would be indicated of the patient (s) personal area.

2.2. The RN and Lead Tech will organize the search on a smaller scale as described in procedures. 1.4. through 1.8.

3.0. <u>Procedure:</u> Personal Patient Body Search

3.1. Whenever a patient returns to the unit from leave status, the patient will be searched.

3.1.1 A personal search will be defined as a non-strip search in which the staff member checks clothing (collars, pockets, sleeves, pant legs, belts, shoes, coats, wallets, etc. to make sure that patients are not trying to bring contraband onto the unit.

3.1.2. Searches will be completed in the Clerk's office before patients are allowed to return to their personal rooms.

3.1.3. All items being brought back into the unit from recreation

activities and crafts will be brought to the Clerk's office by the recreation person or craft person.

3.2 When identified "At Risk" patients return from any off unit activity they are to be searched in a manner consistent with the instructions in 3.1.1 to 3.1.3.

3.2.1. The staff person escorting the patient is responsible to do an initial check before the patient is allowed to move freely on to the Unit (Depending on the situation this could be the patient's therapist, school teacher, rec. therapist or a nursing service person).

4.0 <u>Procedure:</u> Strip Search/Body Cavity Search

4.1. A physician's order must be obtained to do a strip search or body cavity search.

4.2. These will be done in an area that insures privacy for the patient and planned in a manner to maintain respect for his personal dignity.

4.3. Gloves will be worn by the staff members doing the search and/or assisting.

4.4. Only nurses (RN's, LPN's) will do the body cavity search.

APPROVED:

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Unit Administrative Director (Date)

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Unit Nursing Director (Date)

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Unit Clinical Director (Date)

Because security is of major concern, and sometimes doors must be kept locked, we have prepared the following helper in finding specific keys:

3A-1 Opens all exit doors on the building.
3B-1 Opens doors on the unit, patient rooms, garbage rooms, laundry, shower rooms and kitchen.
3B-2 Opens staff offices and recreation supply room.
43 Opens doors to cafeteria.
114 Opens caustic, craft, game cupboards etc;.
Fire Opens fire extinguisher cabinets.

PHONE NUMBER LIST

44609 Student Office
44610 East nursing station.
44611 West nursing station and dayroom.
44612
44679 Steve Haacke, BS.
44614 Denise Stillson, Secretary
44615 Todd Powers, LCSW
44616 Environmentalist / Clerk
44617 Art Miller, MD.
44618 Ron Kelly, LCSW.
44619 Tom Payne, LCSW.
44626 Student Office--Parent advocate.
44630 Diane Maciel, LCSW.

School Staff:

44650 , Secretary.
44651 , Teacher.
44652 Kitchen.
44653 , Teacher.
44654 , Teacher.
44654 Ann Christopherson, Teacher Aide, Media Center.
44656 Linda Black, Teacher Aide,

Call Swithboard 44222
If Patient is dangerous to self or others call
Provo Police 375-1831
Highway Patrol 224-2441
Call Administrative Director, Ron Kelly Cell # 369-7712
.....756-6375
Call Treatment Coordinator:
Todd
Powers.....
.....
Diane Maciel 966-2182
Tom Payne 377-7172
Call the family yourself if you cannot get hold of the Treatment Coordinator.
Check AWOL Information Sheet for pertinent information.
Make sure you have gathered all information concerning AWOL before calling so all questions can be answered on phone: How?, when?, where? and why?.

PATIENT PROGRAM

EXPECTATIONS ON ADMISSION:
It is expected that upon admission, children will be closely supervised until the staff becomes acquainted with the child. Before being placed in the regular treatment program, the child will work with his or her treatment coordinator to formulate some plans and goals specifying what the child thinks is necessary to improve his behavior and what he plans to do to improve his situation.

CARE AND RESPONSIBILITY FOR ROOM:
Children are assigned to rooms containing from one to three beds. They are roomed by themselves or with others according to the assessment as to whether they will function better alone or with other children.

Each child has a night stand, a chest of drawers, and a closet to provide for clothing storage.

The children are allowed to have possessions and room decorations within reasonable limits. Easily broken and valuable property is best left at home, as such items are often short lived.

Care and cleanliness of the rooms are largely the responsibility of the children. With adult guidance, they are expected to make their beds, vacuum their floors, and straighten their rooms before being served breakfast.

CLOTHING:
All clothing is marked and listed at the time of admission. Foster grandparents pick up dirty clothes from in front of the children's room in the morning and take them to the laundry room for washing and drying. They are then taken by the foster grandparents to the various rooms and placed in the dressers. If an item of clothing requires mending, it is sent to the mending room where a foster grandparent makes the necessary repairs.

The children are required to have a clean change of clothing daily unless circumstances such as soiling or wetting requires a more frequent change of clothes.

NEW CLOTHING:
Parents who are financially able, furnish new clothes for their children as the need arises. Funds are made available for children who do not have any financial clothing resource.

PERSONAL GROOMING AND CLEANLINESS:
Baths are given regularly prior to bedtime. Those who wet their beds are required to take a morning bath or shower. The children must be fully clothed with hair combed in order to enter the breakfast area for their morning meal. They each have the necessary teeth brushing equipment, and are encouraged to brush their teeth.

PATIENT MONEY:
Where able, parents furnish a small amount of cash for spending money.

Amounts of $5.00 or less can be left with a nurse on the unit. More than $5.00 needs to be left at the main switch board and will be put in the patient's personal account available for withdrawal at unit request. Money is kept in a money box kept by the Unit Environmentalist. The Patient's can then request money from the Environmentalist. These funds are made available for treats and other incidentals.

MEALS:

The children are fortunate in being able to eat their breakfast in an eating area on the unit. Breakfast is served in a homey, relaxed atmosphere. Eggs, pancakes, french toast, hot and dry cereal, etc., are among the regular breakfast foods, and they are prepared according to the children's tastes as much as possible.

The noon and evening meals are provided by the cafeteria and eaten on the unit much like the breakfast is served.

If food is brought for a patient by visitors, it should be consumed during the visit, since there is not personal food storage space available.

VISITING HOURS:

Visiting hours are flexible, except that late visiting hours that would interfere with bedtime are discouraged. It is preferable that visiting be done between 6 pm. and 8 pm. on weekdays and 9 am. and 8 pm. on weekends. We would ask that whenever possible visitors avoid coming between the hours of 2 pm. And 3 pm. as the staff are trying supervise the patients as well as participate in a "Change of Shift" meeting. Visiting at other times can be arranged with the patient's treatment coordinator. Activities are often scheduled that would preclude visits (small group meetings, off-grounds activities) and it is therefore prudent to contact the ward and make arrangements when a visit with one of the children is desired.

TELEPHONE:

Patients may call home two times per week. Frequent (more than twice weekly) telephone calls are discouraged. Fewer calls are more rewarding and usually the cost of the calls is a factor to be considered. If more calls are needed they can be worked out with the patient's treatment coordinator. Lengthy calls usually do not work out to the child's best advantage. If the youngster is having difficulty controlling his behavior, a telephone call may be deferred.

LETTER WRITING:

The residents are encouraged to write letters home, although this does not happen with regularity or frequency. Postage is provided for three letters per week, and the patients are required to supply any additional postage from their personal funds. Parents are encouraged to keep the communication line open and alive by writing to their children. Parents are welcome to ask friends and relatives of the children to write as often as possible. The patients love cards and letters as they are visible, physical reminders of loved ones.

PERSONAL ITEMS:

A thorough search of each child's belongings is made upon admission, prior to leaving for home visits, and upon returning from visits. This is done to preclude the opportunity of introducing items on the unit that are not appropriate, and to keep items on the unit that were not meant for taking home.

TRADING AND SELLING:
Past experience has demonstrated that trading items by the children leads to disagreements. In order to do away with this source of conflict, trading is usually not permitted, except as a featured special activity, such as a Children's Unit Special Trading Day, which is sponsored by and supervised by the psychiatric technicians.

PETS:
Part of the program of the Children's Unit is to maintain a dog to be used as a therapeutic tool in treating the patients. Several staff presented a program to involve a pet with the patients. The program was approved and the unit now has a pet dog. The responses by the patients has been excellent. Patients who have struggled with people relationships have made excellent improvement.

CURRENT TREATMENT PROGRAM:

The treatment of children at the Children's Unit has been, and will continue to be, dynamic in that it changes to best maximize the skills and personality of the staff when applied to the individual and varied needs of the children. As the population changes, different aspects of the program become more pronounced. Behavior modification principles play an important role in the overall Children's Unit program. Behaviors that are positive and desirable are reinforced with recognition, attention and privileges. Behaviors that are problematic are targeted for extinction by ignoring the behavior. "Natural Consequences" are used both as a motivational tool as well as a way to help the patients learn cause and effects of their behavior.

The behavior program provides coherence and consistency by means of a level system. It has evolved to its present functional form through several years of use and periodic revision with input into desirable changes by the children and staff alike. The Level System provides a means of recognizing positive behavior while at the same time, identifying children who are having difficulty. This system provides a concrete, observable means for the child to measure his/her behavior. It also assists staff in tailoring up to the minute interventions that will benefit the child.

Performance Levels:

In order for the children to be allowed the opportunity for immediate improvement of behavior, they are assessed twice each day. The first period of assessment is from the time they arise until the end of after staff "Change of Shift", approximately 3:00 p.m. The other assessment period is from 3:00 p.m. until bedtime. At the end of these periods, the scores are tabulated and the levels assigned. Each child's score is placed on a score sheet so he/she will be able to receive feedback regarding their behavior and positive reinforcement to maintain good behaviors and encouragement to improve their behavior during the next assessment period.

By this regular evaluation and charting of levels, trends in behavior can be observed. This focuses the attention of the primary therapist on what is happening in the life of each child. It provides a method of non-threatening confrontation about behaviors and can help the child see areas where improvement can be made. Since a majority of the children's time is spent with the attending staff, the major responsibility for determining and recording performance levels, except for during school time, falls on them. Their observation and reports concerning the children's behavior are critical. Additionally, the individual scores are checked regularly in the Children's Treatment Unit Staff Meetings and such follow up minimizes overlooking the particular needs of each youngster.

The Level System is a tool used to measure a child's behavior. The Level System uses the number "5" to represent the children whose behavior is "best" on the Unit or in school. The number "1" is used for those children who are totally out of control, or those whose behavior is so hurtful that the child's interaction must be limited so other children will not be victimized by this child.

The level at which a child has been assessed may be used as a factor to determine which activities would be most appropriate to engage in for that child at any given moment.

Level "5" rating is reserved for those children who exemplify outstandingly appropriate behavior. The youngster who receives this rating is noted as volunteering services in promoting a conflict-free atmosphere on the ward. The school faculty assume the child is a "5" unless misbehavior occurs.

Level "4" is considered an above average Level. This level is for children who have better-than-average behavior on the ward as well as activity . They show motivation towards working through problems, and generally are helpful to the staff and other patients. They differ from Level "5" in that they are not as concerned with those around them.

Level "3" is the average score or level. The children earning this level have had some conflicts and testing of limits; usually they have not gone so far into the behavior as to be disruptive to the ward and unit processes.

Level "2" is a less than acceptable level of behavior and cooperation. Often these children tease, victimize, and fight. The level of fighting is not so severe as to totally restrict them from the other patients. Children with Level "2" may need an up to the minute assessment as to whether they are appropriate to go off grounds for an activity.

Level "1" is, as mentioned, the lowest level. Children with level "1" have been involved in constant testing of limits, or rather serious behavior difficulties such as attempts to hurt themselves, other children or staff, running away from the hospital, or willful and malicious destruction of property. Sometimes patients at this level will be restricted to the unit for protection of themselves and others. However, they can be involved in programing which is clinically justified.

The “Performance Level” system is to be used as an evaluator of patient progress and not as a determination of a patients ability to participate in a particular phase of therapeutic programming. A patient’s participation in an activity is to be determined on the basis of need without reference as to having “earned” the right to participate. Exclusion from a particular phase of programming is based on an evaluation by unit staff which indicates that the patient’s current emotional state would prevent safe participation either for the patient or others.

Modifications of Performance Level System:

We often deal with children who require a much more structured, observable program than the regular level system. To deal with this problem, we have placed these children on a restricted or slow-down program where they are taken right out of the general program until the staff feel that there is an interest in participating in the total program or until sufficient headway can be made so they understand the rewards they receive for appropriate behavior. These slowed down programs can take several forms, one is that the child can receive scores even more frequently, up to once each hour. Another way is for a "Token" program to be tailor-made for the individual needs of the child allowing him to earn a type of token that can be spent for activities rather than earning activities by a level system. This is much more concrete for the patient and he/she can

learn to associate the appropriate behavior with the ability to choose desired reinforcers.

Individual Therapy

Individual therapy is scheduled with all patients. Each patient is assigned to a primary therapist or "one-to-one" who meets with him one to two times a week or more often if necessary. Individual therapy has many focuses and is tailored specifically to the needs of the particular patient at a specific time. One basic goal of all individual therapy is to help the patient develop trusting relationships with adult figures.

Play Therapy

Play therapy is a dynamic interpersonal relationship between a child and therapist trained in play therapy procedures. Children's natural language is play; a symbolic language of self expression children use to give expression to their experiences and emotions. The therapist provides selected materials, toys, and activities giving children opportunities to express themselves through a variety of mediums (art, sand tray, water play, dramatic play, fantasy play, experiential play, skill building activities, etc.). Play is a rehearsal for life. Through play therapy, children can recreate at their developmental level, issues representing emotional conflicts influencing their present behavior. Through facilitative skills such as therapeutic limit setting, tracking, empowerment recognition, context restating, reflecting feelings, etc., the therapist helps develop a safe relationship with children allowing them a sense of security when working through their issues.

The objectives of the play therapy process are that children can change their personal view of events in the world and begin to better enjoy their interactions with others. Through play, children are able to communicate what they cannot say, do things they would feel uncomfortable doing, and express feelings they may be keeping inside. They learn self- control, self-direction, and responsible freedom of expression. Children also learn through the play process and relationship to respect themselves, accept themselves, to be creative and resourceful in confronting problems, to make choices and assume responsibility for their choices.

Currently, play therapy is utilized with all of the patients primarily on an individual basis but often in conjoint sessions with other patients and even siblings. In addition, filial play therapy can extend and reinforce the child's therapeutic play experiences from the hospital unit to home by training family members in therapeutic play therapy skills.

Group Therapy

Currently many (some patients are not able to handle group interactions and thus are not placed in groups until the treatment team feels that it would be beneficial to the patient.) patients are assigned to meet in group therapy at least one time per week. The different groups are tailored for the specific populations. The model of each group is developed by the primary therapist for the specific needs of the patients in the group. Some groups may be activity oriented, while other groups are more traditional. As group members change, so does the focus of the group to more readily meet the needs of the group members.

"Second Step"

All of the patients experience the "Second Step" anger management program. This a structured treatment approach which emphasizes understanding feelings and emotions and developing strategies for dealing with differences.

Victims Group

With the majority of the children at this facility experiencing some form of sexual victimization, a group format has been developed to address the psycho educational aspects of victimization. While some issues of victimization are addressed on an individual basis, the goal of this group for the Unit is to provide consistency in presentation of information among therapists. The clinical team makes recommendations as to which children ought to attend at particular time. The group format consists a psycho-educational orientation emphasizing the following:

1. "I'm in charge of me."
2. "All you gotta say is no."
3. "Feelings"
4. "I'm in charge of my body."
5. "Secret touching."
6. "Perpetrator influences."
7. "Resolution strategies."
8. "Who can I tell?"
9. "Fault and responsibility"
10. "Self esteem building."

Additional group activities are drawn from "Superkids: a boys group about abuse" (Joanne McCharty), to facilitate group objectives. The group is maintained on an open ended format.

Sexually Reactive Group And Individual Therapy:

The Children who have a history of being sexually reactive are considered for placement in the "Sexually Reactive" therapy. It is an open ended therapeutic process that is not time limited. The goal of this therapy is to help the child be able to learn skills and develop abilities to understand and control their sexual thoughts, feelings and behaviors in socially acceptable ways. Treatment issues are addressed which include the following:

1. Ability to Identify Feelings.
2. Anger Management.
3. Relaxation Skills.
4. Empathy Skills.
5. Issues of Accountability.
6. Social Skills.
7. Forming Appropriate Boundaries.
8. Human Sexuality/Maturation.
9. Developing a Healthy Sense of Self.
10. Communication Skills.
11. Cycles.
12. Cognitive Skills.

Several sessions are utilized to address each area and repetition of concepts

takes place according to the needs of each patient or the group.

Community Group

When patient behaviors on the unit require added structure the staff on duty call a “Community” meeting. This involves all the patients and staff on duty. During "Community", patients and staff are given the opportunity to discuss various concerns. They are given positive reinforcement for the activities of the day and are given a chance to express frustrations and problems they're having in dealing with living on the unit. It is a time for all the patients to work on problem solving and a time for helping the children recognize the needs of others as well as their own. This program requires a great deal of staff supervision and involvement as the patients are in the process of learning how to get along. Particular attention needs to be given by staff to keep the pressure appropriate and therapeutic for the patients involved.

Family Therapy

A sincere effort is made to involve parents in a counseling program so they can deal constructively with their family's emotional requirements. We want families to feel that we want to work with them and together make their home environment satisfying to all family members. One area which has proven to be very effective is to involve the family in “inter- actional activities” under the direction of the Recreation Therapist. Family members have also been involved in some of our “off grounds” activities such as skiing.

For Families who do not live near the hospital family therapists assigned to each patient will (when possible) meet at the family's home. Parents who are close to the hospital are encouraged to meet regular for family sessions at the hospital. Those families who are unable to participate in activities at the hospital or in the community because of transportation or other problems, are kept involved through frequent telephone consultations from the staff at the Children's Treatment Unit.

There are times when we will run a "Parent Support" group. Children do not attend this, but parents are able to discuss their own situation and learn from the growth that has been experienced by other group members along with better understanding the difficulties of dealing with an emotionally disturbed child.

HOME VISITS

Home visits are encouraged on the Children's Treatment Unit for several reasons. It is felt that the children need to have frequent contact with their family. The goal of the visits is for the patient to have the opportunity to interact with their family in more successful ways than prior to their admission. With frequent home visits, changes that are gradually made seem to be more acceptable and understood by parents. As parents meet with staff members, goals are set to help in the treatment at home as well as in the hospital since the children have not been successful in their homes. Home visits are also a measure of the changes the children and their families are making. Home visits are also encouraged so a child does not become institutionalized. Not all of the patients have homes and families to visit. The staff will try to have these patients visit with relatives or foster homes. On occasion there might be a volunteer family involved with a particular patient.

PROCEDURE

1. When the children qualify for a home visit, it is approved by the "treatment coordinator" and the unit doctor after a discussion with the treatment team. Home visits are also coordinated with the parents as well as Community service caseworkers, if appropriate.
2. When ever possible these arrangements need to be made prior to Wednesday of each week so as to give the Hospital Pharmacy time to prepare home visit medications. Home visits are written in the Physician's Orders as well as the Progress Notes.
3. Unit staff will chart medications taken with the patient, the time they leave, who picked them up, and what personal items such as toys and clothing that the patient is taking on the visit.
4. Each patient will bring a "Home Visit" form which contains objectives for the visit as well as a brief explanation of performance scores and a section for the family to rate the patients level of goal achievement. The feedback section of the form is to be completed by the parents and returned to the hospital when the patient returns to the hospital.
5. Parents are also encouraged to check their child's travel bags prior to returning to the hospital. (It should be noted that, as a safety precaution, each patients personal belongings will be examined as they return to the unit.) The following represents a brief list of items which should not come with a patient to the hospital.
    1. Posters, books, magazines or Toys which depict or lead to violence.
    2. Sharp objects such as knives, scissors. nails, screws or hand tools of any kind.
    3. Expensive or irreplaceable personal items because they could be damaged or stolen.
    4. Large items such as bikes, scooters and skateboards.
    5. Any type of trading Cards or other current fad type toy (a current example would be anything relating to "Pokemon").
6. When the patient is returned to the hospital, the time, who brings them back, what personal items they bring back and a brief statement regarding performance on the visit, are again charted in the progress notes.

RECREATION PROGRAM:

The role of play activities in the growth, development and education of children is of utmost importance. Through play experiences children are able to explore, experiment, observe and gain experiences that help them to learn a wide scale of values which form the basis of their thinking patterns and attitudes abut themselves, their families, their playmates and the world around them. The play experience also provides the child with valuable opportunities for constructive skill learning. Recreation therapy is an important and active treatment modality

used in unit programming. The overall goal of the recreation therapy program is three fold:

1. Improve the quality of life.
2. Improve the level of social - emotional functioning.
3. Strengthen the self concept of each patient.

This is accomplished by providing positive activity experiences from which the children can grow. We work to help each child develop and improve functional behavior and healthy coping skills. We work to help each child to transfer what they learn through recreation into other aspects of their lives.

The recreation therapy program is designed to meet the physical, mental, social, and emotional needs of each patient. Programming, therefore, is based on the needs, interests, abilities, and desires of the patients. Because recreation therapy is a reality based therapy it provides valuable information in helping the staff to understand and evaluate the progress of the patients. Many of problems the patients have show up in recreation activities. It is very difficult for anyone to hide feelings, emotions and attitudes while participating in a recreational activity.

There three major aspects of the recreation therapy that we emphasize in the program.

1. Therapy- In therapy we focus on modifying or eliminating dysfunctional behavior that interferes with successful participation in activities. We reinforce positive behaviors that are expressed and observed. Self concept is strengthened as cycles of failure are broken and the patients increase their ability to feel good about themselves.
2. Education- In this area we focus on teaching awareness of play and recreational opportunities, age appropriate skills, positive attitudes and social skills. We emphasize awareness, skills, and attitudes about those activities that can be done on a day to day basis at home and school.
3. Participation- In this area we provide opportunity for the patient to participate in activities of interest to them and when feasible give them the chance to choose the activity they will do. The focus is on having fun and the enjoyment of participating in recreation and play activities.

Activities are adapted and modified when necessary to meet the needs of the patients and increase the chances for each child to have positive experiences. We work to carry out activities in a supportive atmosphere where effort is valued. Almost all of our activities take place in a small group or individualized setting. This approach helps ensure a good staff / patient ratio, good supervision, and individualized attention. We do leave large group activities (112 or more patients) in connection with some of our community based activities.

Listed below are some examples of specific problem areas where Recreation therapy objectives are written and included on the “ICTP”.

Low Self Esteem	Short attention span
Aggression	Poor social skills
Depression	Poor peer relationships
Impulsiveness	Anti-social behaviors
Destructiveness	Inappropriate sexual behaviors

Examples of activities that are used in the unit programming include:

Downhill skiing	Initiative games
Cross Country skiing	Bicycles
River running	Service projects
Fishing	Sports - team and individual
Camping	Crafts
Climbing	Ceramics
Hikes	Community based events
Picnics	(Bowling, Museums, Sports events,
Horseback riding	water parks etc.)

The success of the Recreational Therapy Program is very dependent on the support given by the staff. The program must have the participation of the staff in order to be highly effective.

General Ward Routine for New Patients:

1. The patient and parents have the "Patient's Rights" explained to them.
2. Unit psychiatric technicians check the patient into the dorm, identifying belongings and assigning a room.
3. The patient is given an orientation to the unit procedures by staff or another patient on the first day. Often, a more responsible patient is assigned to be a "buddy" for the new patient to help him integrate into the unit program.
4. Within 24 hours, the patient is given an initial psychiatric exam and physical examination.
5. Throughout the first two weeks, the patient participates in a complete workup including assessments by all of the professional disciplines.
6. Patient Programming:
    a. Each patient is assigned a "Treatment Coordinator" within the first day of admission.
    b. The patient is restricted to the unit and school for the first two or three days (depending on his past history and current behavior) and meets with his treatment coordinator to establish some performance goals.
    c. School placement tests are given before the patient is allowed in the classroom.
    d. Off-ground activities are generally available after a week in the hospital.
    e. The patient's family is contacted within the first week and given an initial adjustment report. Arrangements are also made at that time for an initial family visit with the child. This visit should not occur until the patient has been in the program for at least a week. This gives our staff an opportunity to observe the patient separate from his family.

PATIENT'S TREATMENT TEAM

UNIT ADMINISTRATIVE DIRECTOR: RON KELLY # 344-4618

	NAME	PHONE
PSYCHIATRIST	**Art Miller**	**344-4617**
SOCIAL WORKER (TREATMENT COORDINATOR)		
NURSE		
REC. THERAPIST	**Steve Haacke**	**344-4679**
PSYCH. TECH.		
CASE MANAGER (From CMHC)		
DFS WORKER		

Family members, especially parents, are encouraged to participate with the treatment team at admission and every 90 days to develop treatment goals, monitor progress and to develop a discharge plan. Other meetings may be

scheduled as needed.

PATIENT'S DIAGNOSIS- GOALS

DIAGNOSIS: GOALS

_____

_____

_____

MEDICATIONS:

Medication	Purpose	Possible side effects
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Complete descriptions of Patient Programming is contained in section I.

QUALITY IMPROVEMENT PROGRAM

Quality improvement objectives and results are maintained on the unit in the "Pediatric Services - Children's Unit" Policy and Procedure manual.

Copies of these documents are also kept in the Hospital Quality Improvement office.